S. HRG. 103–838

HEALTH INSURANCE MARKET REFORM

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

FEBRUARY 1, 1994

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE

81–835—CC WASHINGTON : 1994

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-046253-3

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HEALTH INSURANCE MARKET REFORM

TUESDAY, FEBRUARY 1, 1994

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:25 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Daniel Patrick Moynihan (chairman of the committee) presiding.

Also present: Senators Baucus, Rockefeller, Daschle, Conrad, Packwood, Roth, Danforth, Chafee, Durenberger, Grassley, and Hatch.

[The press release announcing the hearing follows:]

[Press Release No. H–4, January 28, 1994]

FINANCE COMMITTEE SETS HEARING ON HEALTH INSURANCE MARKET REFORM

WASHINGTON, DC—Senator Daniel Patrick Moynihan (D–NY), Chairman of the Senate Committee on Finance, announced today that the Committee will next week resume its series of hearings on issues relating to health care reform. Senator Moynihan stated that the first of this year's hearings will examine health insurance market reform.

The health insurance market reform hearing will begin at *10:00 a.m. on Tuesday, February 1, 1994* in room SD–215 of the Dirksen Senate Office Building.

"There is much agreement that insurance market reforms are needed and will be a central part of health care reform. We will hear from a number of experts in the field and seek some consensus on these very important issues," said Senator Moynihan.

OPENING STATEMENT OF HON. DANIEL PATRICK MOYNIHAN, A U.S. SENATOR FROM NEW YORK, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. A very good morning to our distinguished witnesses and our guests on this the first hearing of the Senate Finance Committee in the second session of the 103d Congress. The session in which, as I observe a beaming Senator Rockefeller, we are going to enact universal health care coverage and health reform generally, along the lines that had been proposed by a number of the distinguished members of this committee, whose legislation we have before us, not the least that of Senator Chafee.

We had an important event yesterday. It happens I have just come from a meeting with the National Governors Association, Governor Rockefeller, on the subject of welfare reform to carry on the work that was done by then-Governor Bill Clinton as Chairman and Governor Mike Castle, now Representative Mike Castle of Delaware. This is a bipartisan effort with much energy and much agreement with the President that welfare is an issue very closely

tied to health care reform. To do the former, you will need to do the latter.

The Governors had an important meeting with the President yesterday, as reported by David Broder and William Clayborne on the front page of The Washington Post, and I can say confirmed in conversations I had at the Marriott Hotel just now, in which they have Governor Clinton as saying, "he was as opposed to price controls"—which is to say premium caps—"as they were and had included them in his plan only to satisfy the scoring requirements of the Congressional Budget Office."

Well, now President Clinton is one of us. [Laughter.]

I mean, he has come upon the scoring requirements of the CBO and other such matters, all of which are very promising in terms of moving forward to a consensus in this matter. The Governors, I just note, issued a unanimous bipartisan statement calling for health reform with various details.

This morning we are going to deal with one of the first issues that arises, on which there is a very wide range of agreement that we have to act, and that is health insurance market reform.

I would note that our former colleague Senator Bentsen, now Secretary of the Treasury, introduced legislation along these lines with Senator Durenberger. I believe it passed and it just could not make its way all the way to enactment. But, obviously, this year it is going to do so.

I think I have talked enough already. I turn to my colleague Senator Packwood.

OPENING STATEMENT OF HON. BOB PACKWOOD, A U.S. SENATOR FROM OREGON

Senator PACKWOOD. Mr. Chairman, you indicated yesterday was an auspicious day. Today is also. Today is the day that Oregon's Medicaid waiver plan goes into effect. We will be bringing 120,000 Oregonians who have not been previously covered under Medicaid. We made a tradeoff and it has had wide publicity.

We said we would cover a lot more people. We were covering way below the poverty level, as most States do. We would bring it significantly up but we could not cover everybody for everything.

So we set up a health commission and we prioritized health care based upon effectiveness of treatment. The common cold will no longer be treated on the assumption that there really is no effective treatment.

Cosmetic surgery for purely cosmetic purposes—you just do not like your face and you want to change——[Laughter.]

The taxpayer is not going to pay for it, even though it might be cost effective, more so in some cases than others. [Laughter.]

I was delighted to have a hand in getting that Medicaid waiver. We tried and tried and tried during the latter years of the Bush Administration and did not get it. But to President Clinton's credit he granted it and it started today.

In this hearing today though I am going to focus on universality. Everybody says we want it. I want to make sure everybody wants it or at least is talking about the same terms because I find often we use the same word and everybody does not mean the same thing.

Second, about community rating and how far we should go in it; and do we want to go as far as Social Security, which is the ultimate community rating, I guess. You pay the same for it whether you are 45 or 25, a percentage of wages. You pay for it whether you smoke or do not smoke. You pay for it whether you are sick or healthy.

Do we want to move in that direction in terms of health insurance or do you want to have geographic differences, and health differences, and age differences, and family dependency differences and still have community rating within those differences?

Those are issues that I will be posing. Then, very frankly, asking the witnesses the question, if you believe in universal coverage, can we get there without—I will call it compulsion. Some people call it mandates. If we say we want it, but we are not going to demand it, enforce it, can we get there?

If there is a way to get there without mandates, without compulsion, I am all for that. But if we want it and we cannot get there without mandates, I would appreciate any suggestion someone else has to get there.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Packwood.

Senator Baucus, do you have any suggestions?

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA

Senator BAUCUS. Just one, Mr. Chairman. That is, as we address the questions that Senator Packwood and yourself raised, I think there are additional questions. As we move toward universality, which I think is a general goal for all of us, will insurance reform in and of itself be able to assure us that premium costs will not continue to be too high for too many people and small businesses.

The next question then is your question, Senator, and that is, is a mandate, the only way to get toward this question of cost controls. Even with mandates, there is still a question on how you assure that costs are not too high or out of the reach still for too many people.

They are fundamental questions, frankly, that I think get to the heart of the matter for the various health bills before us. That is, is insurance reform enough? I am not convinced that it is. The next question is, if it is not enough, how do you get further down the road? That is, kinds of community rating that you really want without some kind of compulsion.

We have compulsive automobile insurance. Maybe someone is suggesting we should not have compulsive automobile insurance. You know, let people buy who want to buy, have rating bands and so forth for auto insurance. Then the next question is cost. Are costs still going to be too high. And if so, what do we do about insuring the costs are not out of reach for too many small businesses and too many individuals.

Thank you.

The CHAIRMAN. Thank you, Senator Baucus.

And very well, Senator Chafee, what are we going to do?

Senator CHAFEE. Well, I have outlined it in an excellent bill that I have submitted before this committee. [Laughter.]

OPENING STATEMENT OF HON. JOHN H. CHAFEE, A U.S. SENATOR FROM RHODE ISLAND

Senator CHAFEE. Mr. Chairman, I am delighted we are going to start on this. I will just briefly say, one of the questions I will be interested in hearing the answer to is: If we go to community rating, is that going to produce such a shock among certain groups, say the young people who are currently getting their insurance at a relatively lower cost is that going to undermine support for the whole program that we are involved in?

Every single one of us, most of here on this committee, lived through the catastrophic legislation, which was catastrophic in more than one way, and we saw a bill that passed in the Senate, something like 88 to 12.

The CHAIRMAN. And it was repealed.

Senator CHAFEE. A year later. And certainly none of us want that to occur in this program. So the question is, should we plunge full bore immediately into community rating, total community rating, or should we move into it in somewhat of a more gradual fashion.

That would be my question, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Chafee.

I think it is a question we hope all of our witnesses will address.

Senator Rockefeller, you have been much involved with this.

OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER IV, A U.S. SENATOR FROM WEST VIRGINIA

Senator ROCKEFELLER. Thank you, Mr. Chairman. I want to first say something that disturbed me when I read it in The Wall Street Journal this morning. There was the implication that the President's threat to veto a bill had some relationship to the fact that Senator Chafee, who has long been a champion of universal coverage, suddenly supports universal coverage. I just wanted to clear that up.

Senator Chafee has been here for a very long time. I do not think it takes the President's veto to do that.

Second, I was not entirely pleased with the meeting that the President had yesterday with the Governors, not based upon just what he said, but based upon matters of process.

We have some pretty good people on health care on this Finance Committee. The President has made his proposal. It came to the Congress with a number of political compromises in it, which had been made over a period of time during the course of the task force. Always throughout this process there has been the assumption, in fact for many years, the assumption that health care does not work unless you have a combination of universal coverage and very effective, tough cost containment.

I have been a Governor. I was a Governor for 8 years. I enjoyed it. I like Governors. I like to be around Governors, but I am more interested in health care than I am in the collegial feeling of being with Governors.

The President indicated, as you indicated, that he was opposed to price control and he sort of had to do it because of CBO. He also appeared to indicate—and I watched this on McNeil-Lehrer last

night, that whether or not you belong to an alliance was very much a matter of being up in the air.

Senator Bentsen, and I do not disagree with him at all, went before the National Association of Manufacturers the other day and indicated that maybe the level did not have to be 5,000. And, indeed, it does not have to be 5,000. But that is my point.

The President has proposed the legislation. It is "we" now in the various committees of Congress, most particularly in the Senate Finance Committee, who will dispose of this legislation.

There are people like John Chafee, and Dave Durenberger, and Orrin Hatch, and Jack Danforth, and Bob Packwood, just on the Republican side, and many on this side, who have been working on health care a very long time. We have, as the chairman knows, with his permission, a system whereby we are meeting as Senators alone without staff. Our staffs have been meeting during the recess.

We are working towards reaching accommodation on this. But when somebody suddenly as important as the President of the United States suddenly raises questions about cost containment, I find that not particularly useful. So I would caution him and indicate that there would be, as the Post or one of the other papers indicated, it would be more than Jim McDermott who will be upset if he starts making deals up there when the legislation is with us.

I will point out that he is speaking to the Governors at 11:00 on health care. I hope that others have spoken to him and that the speech will be somewhat different. [Laughter.]

Senator ROCKEFELLER. It is a concerning matter to me, Mr. Chairman, because I value the level and the depth of knowledge about health care that resides on this committee. And, it seems to me, it is on this committee and others in the Congress where we have to work out this compromise, and compromise there will have to be.

The CHAIRMAN. Very well stated, sir.

Could I record that we are being watched by C-SPAN and there is still a chance for the President to have watched what you just said before he goes over to the Marriott Hotel.

Senator ROCKEFELLER. I hope so.

The CHAIRMAN. Now Senator Durenberger, who has been so very much involved in these matters.

OPENING STATEMENT OF HON. DAVE DURENBERGER, A U.S. SENATOR FROM MINNESOTA

Senator DURENBERGER. Mr. Chairman, if it is, in fact, that we still have 21 minutes, I am not going to take it all, but I would like to affirm in perhaps a slightly different way what my colleague, Jay Rockefeller, just said to the President and maybe make two points.

One, that health care reform did not start with Bill Clinton or Hillary Rodham Clinton, but I am sure glad that they took it on. And everyone on this side of the aisle has always given credit to the President and to Hillary Rodham Clinton for doing it.

The people that are still on this committee on this side of the aisle are the original health care reformers. Bob Packwood and Bob Dole have been doing health care reform since before I got to this

committee in 1978. I learned about how to do it from them and they are still here; and they are still committed to doing it.

We participated in 1979 in this committee in defeating a regulatory approach to cost containment. We then came back in 1983 when Senator Baucus was the ranking member of the Health Subcommittee and I was lucky enough to be his chair, we did DRG's, began the process of putting prices on hospital products which in effect changed the nature of the hospital industry in this country.

We followed that up with Senator Mitchell when he was the Ranking Member of the committee with Medicare Catastrophic. When Jay took over, we did RBRVS. We did AHCPR. I hate to use these acronyms. I mean, reform did not begin this year and it is going to take a long step forward this year.

But the reality of what my colleague from West Virginia just said is that there are nonpartisan, bipartisan traditional efforts to reform this system. And practically all of them have originated right here in this committee among the people who are still here to help the President and Mrs. Clinton do it in 1994, hopefully by August 15.

The second point I would like to make, Mr. Chairman, is something I have learned. I have found that now that I have made the decision not to run for a fourth term, I have learned a lot more than I thought when I was thinking of myself as a candidate and all the rest of that sort of thing.

You referred to the fact that Lloyd Bentsen and I introduced the small group insurance form bill that actually passed the Senate. Two of the things that are valuable lessons for all of us to learn—and President Butler, I think, at Columbia gets the credit for saying this—you can either get the job done or you can get the credit for it.

In this body we see, or in politics in general I guess we see, both kinds of folks. I put a high value in getting the job done, particularly now that I am not running for anything. I cannot say I always felt that way. I think I always felt like I needed the credit for these things as well.

But the second lesson I have learned that is very valuable is, if you have a good idea and you know from your constituency that it can work, the best way to assure its success is to give it away. I just share that with my colleagues, as at least in my case a proven quantity.

We have such a reform before us today. This began in Minnesota right after the Pepper Commission completed its work—the Rockefeller Commission. You talk about the essence of compromise and how to get the job done, you did it in that Commission as you did in the Commission on Children, Jay.

My staff, Kathy Means, together with Dave Gustufson, who was then on loan from the PBGC, is now back at PBGC, designed the insurance reform bill that we are going to be talking about today and that is incorporated in most of these pieces of legislation.

Passage of this, we introduced it first as S. 3260 in October of 1990. We refined the product as S. 700 in 1991. We gave it away, recognizing political realities as S. 1872 at the latter part of 1991 and the then-chairman of this committee, very committed to that,

as he is today, passed it through the Senate on at least two occasions.

So, Mr. Chairman, I just maybe in a different way will say to the President that he has done a lot of compromising already with various interests in this health care reform bill I think for the elderly and the unions. It is kind of now the time where we all get into the effort of working this thing out.

I am pleased with the progress that is being made. I am pleased with what the Governors are doing and others are doing. But I do want to say in respect to my colleagues in this committee, as you, Mr. Chairman, know so well, that there is a capacity here and there is certainly a commitment over 20 years here to get this job of health care reform done and to do it this year.

[The prepared statement of Senator Durenberger appears in the appendix.]

The CHAIRMAN. Very properly stated, sir, if I may. And just for those who may have missed it, AHCPR is the Agency for Health Care Policy Research; PBGC is the Pension Benefit Guaranty Corporation. [Laughter.]

Senator Grassley?

Senator CHAFEE. How about RBRVS? [Laughter.]

Senator GRASSLEY. Mr. Chairman, if it will not disappoint you, I am going to pass for an opening statement.

The CHAIRMAN. Sir, there is plenty of time.

Senator Hatch?

OPENING STATEMENT OF ORRIN G. HATCH, A U.S. SENATOR FROM UTAH

Senator HATCH. Mr. Chairman, I thank you for holding the hearings on health insurance market reform. I think they are important. I look forward to hearing the witnesses today.

But I hope today's session will prove a positive one. I, for one, for instance, have been distressed that insurers have become the bad guys around here. In fact, the health insurance industry provides a very high level of service at a very low profit margin.

True, there are problems with health insurance, as I believe our witnesses will readily recognize today. For instance, last week Mrs. Michelle Brown of Salt Lake City visited my office. Her husband, Larry, had lost his health insurance 3 months ago, after having been diagnosed with AIDS.

Mrs. Brown came not to seek fault, although she surely had some reason to do so, but ask bravely for improvements in the system. The improvements that she sought will make certain that other mothers and children do not have to risk financial security to scramble for credit in order to pay for the comfort and care of their critically ill loved one.

That is a problem in the system that we need to fix and we are all trying to get about that in the United States Senate. But that does not mean that the system is irretrievably broken.

In all our rush to find fault, we seem to be ignoring the fact that the majority of our population has good health insurance and our aim should be to correct the deficiencies and reform the process.

Several of the bills before this committee improve on that. For example, by guaranteeing issue and allowing for preexisting condi-

tions that will give millions of Americans the security of knowing that they can obtain and retain their health insurance whether they become sick or they change jobs.

That being said, I want to say I look forward to hearing the testimony of our experts here today. I appreciate you holding these hearings and I think we are well on our way to trying to resolve some of these problems.

The CHAIRMAN. Thank you, Senator Hatch.

May I just also note for the record that the sequence of topics which we will be holding hearings on has been worked out between our staffs on both sides of the aisle. Senator Packwood and I asked that we proceed this way on issue-by-issue rather than bill-by-bill.

So now Senator Danforth.

OPENING STATEMENT OF HON. JOHN C. DANFORTH, A U.S. SENATOR FROM MISSOURI

Senator DANFORTH. Mr. Chairman, this is a very interesting topic. I think that the most interesting question is whether insurance reforms have the effect of removing incentives, financial incentives certainly, for people to try to stay well.

I have supported the idea of insurance reforms. Now I made a speech in Springfield, Missouri not long ago on this subject, touting the importance of health care reform and insurance reform, among others, community rating.

Then at the end of the speech in the question and answer period, the manager of a small business raised his hand and said, you know, at our business we try, and we make a big effort, trying to keep people healthy. Should we not be encouraged to do that?

I think that the answer to that question should be yes. I am wondering if that goal is in conflict with what we are trying to do otherwise in this legislation. I will be interested in hearing from the witnesses.

The CHAIRMAN. You certainly will. Another subject for our witnesses.

Senator Conrad?

OPENING STATEMENT OF HON. KENT CONRAD, A U.S. SENATOR FROM NORTH DAKOTA

Senator CONRAD. Thank you, Mr. Chairman. I just spent 5 weeks at home in North Dakota going from one town to another and——

The CHAIRMAN. Snowdrift to snowdrift.

Senator CONRAD. Snowdrift to snowdrift. We had plenty of that—51 inches in my hometown. I did a lot of listening to the people of my State, and a lot of listening on this subject, because it is very important to the people of North Dakota, as I know it is to the people of all the States represented around this table.

Over and over what people were saying to me is universal coverage is important to them. They also talked about the skyrocketing costs because we have just learned from Families USA that North Dakota has the highest proportion of its citizens' income going for health care of any State in the nation. We are number one.

That is putting enormous pressure on the budgets of families, businesses, and even of governments because it is the fastest grow-

ing part of the budgets of every level of government. So I want to start this series of hearings by saying cost containment is something I am going to be looking at and feel strongly about. It is critically important that we accomplish that as we proceed.

I also have heard over and over from the people of my State streamline and simplify. Streamline and simplify. People are very concerned that the superstructure that is part of the President's plan needs to be simplified and streamlined. So those will be guiding goals for me as we move through this process.

I appreciate very much, Mr. Chairman, your calling this set of hearings. I think you have done a splendid job, along with others, of organizing them.

The CHAIRMAN. Thank you, Senator Conrad.

And finally, Senator Roth.

OPENING STATEMENT OF HON. WILLIAM V. ROTH, JR., A U.S. SENATOR FROM DELAWARE

Senator ROTH. Well, thank you, Mr. Chairman. Let me join in congratulating you for the series of very important hearings that you have scheduled throughout the spring.

I will be very brief. I just would like to make one comment, however, on a proposal that I have made the last 2 years to point out that the one issue the President underscored in the State of the Union Address was, of course, universal coverage for all Americans.

There has also been a great deal of discussion that we should make available to the public the coverage we have here in the Congress and the Executive Branch. What my proposal has been is to open up the Federal Employee Health Benefit Program to small businesses and others that are not covered.

It has been estimated that by opening up the Federal plan under my proposal, we could cover as many as 10 million additional insured. So I think this is a very important proposal that does help extend coverage without creating any major new bureaucracy. It does make available to the public at large what we now have.

I would also say, Mr. Chairman, my proposal would incorporate small business insurance market reform, which I think is critically important. I will be talking about it further.

The CHAIRMAN. We look forward to that.

Well, now just about on schedule we begin our distinguished witnesses. They are Dr. William Custer. Gentlemen, you know who you are, come on up. Dr. William Custer, Dr. David Helms.

Dr. Custer is the Director of Research of the Employee Benefit Research Institute; Dr. Helms is President of the Alpha Center, a research group here in Washington, DC; and Salvatore Curiale, the distinguished Superintendent of Insurance in the State of New York, where community rating has just been adopted and we are going to hear from the first State who has done it.

In accordance with our listing here, Dr. Custer, would you begin. We will hear each of you. If you could keep yourselves to our timing here. Then we will have time for questions. Good morning.

STATEMENT OF WILLIAM S. CUSTER, PH.D., DIRECTOR OF RESEARCH, EMPLOYEE BENEFIT RESEARCH INSTITUTE, WASHINGTON, DC

Dr. CUSTER. Good morning. Thank you, Mr. Chairman.

The CHAIRMAN. All statements will be placed in the record as if read.

Dr. CUSTER. I represent the Employee Benefit Research Institute. We are a nonprofit, nonpartisan public policy research organization whose mission is to provide objective analysis of health care, retirement income security and other work force issues.

The last 5 years we have tabulated and published estimates for the sources of health insurance coverage, from the March Supplement to the Census Bureau's current population survey. The latest available data is the March 1993 survey which has data and health insurance coverage for 1992.

In 1992 71 percent of non-elderly Americans, that is Americans under the age of 65, had private health insurance; and 62.5 percent had coverage through an employment-based plan. While the majority of Americans continue to be covered through an employment-based system, that source of coverage is eroding for many groups, especially those who live in low-income families or work for small employers.

Between 1988 and 1992 4.2 million more Americans were uninsured. The number of uninsured increased by 2.2 million between 1991 and 1992 alone. The number of non-elderly Americans with employment-based coverage in 1992 is 138 million, a decrease from 139 million in 1991.

Now there has been some confusion about numbers of people without health insurance in this country. I would like to take a little time to clear that up. Most researchers familiar with this current population survey agree that it gives estimates of the sources of coverage at a point in time during 1992.

Another Census data survey, the Survey of Income and Program Participation follows a smaller group of individuals over a 2½ year period. The latest available data from SIPP is from 1987.

Adjusting those number from SIPP for population growth and increases in the number of uninsured to make them comparable to the 1992 current population survey yields estimates that 25 million Americans were uninsured for the entire year of 1992; 38 million Americans were uninsured at any given day during 1992; and 58 million Americans were uninsured for some portion of 1992.

Turning back to the estimates from the current population survey, we found that increases in a number of individuals on health insurance are greatest among those whose family had worked for a small firm.

Between 1991 and 1992 42 percent of the additional 2.2 million individuals without coverage were in families where the family had worked for an employer with fewer than 25 employees. An additional 15 percent were in families in which the family had worked for an employer with between 25 and 99 employees.

The clients in the employment-based health insurance coverage were somewhat offset by increases in number of Americans with coverage through a public source. In 1992 33.4 million non-elderly

Americans received public coverage compared with 26.2 million in 1989.

The increase in public coverage is due in part to increases in Medicaid coverage for children and pregnant women and in part due to the effects of the recessions, which pushed people's incomes to a level where they become eligible for Medicaid coverage.

Not surprisingly, workers are much more likely to have coverage from an employment-based plan than nonworkers. Seventy percent of workers were covered by an employment-based plan compared to only 37 percent of nonworkers.

In addition, 77 percent of individuals and families headed by a full-time, full-year worker were covered by group health plans compared with 37 percent of those in families headed by other types of workers and 16 percent of the individuals in families headed by a nonworker.

Workers will also more likely be covered by an employment-based health plan if they work for a larger employer. Premium costs are lower for larger employer plans because they are able to spread the administrative costs over more individuals and the risks are pooled over more individuals.

Only 23 percent of self-employed workers and 22 percent of workers in firms with fewer than 10 employees were covered through a group health insurance plan sponsored by their own employer, compared with 70 percent of workers and firms with 1,000 or more employees.

Income is also related to health insurance coverage. In general, individuals with higher levels of income are more likely to be covered by private health insurance. In 1992 only 16 percent of individuals with families' income below $5,000 a year were covered by private health insurance compared with 92 percent of families with family income of $50,000 or more.

Among the 38.5 million Americans who were without health insurance in a given day in 1992, most were working adults—57 percent—while the rest were children or nonworking adults. The uninsured live in families that are low income and employed by small employers as I just said.

Over 60 percent of the uninsured live in families with total a family income of less than twice the rate of poverty level; 51 percent of the uninsured live in families whose family head works for an employer with less than 100 employees. The uninsured also tend to be young. About 25 percent of the uninsured are children under the age of 18.

But even among adults, the uninsured tend to be younger than those with coverage. Twenty-seven percent of those aged 18 to 29 were without health insurance coverage in 1992 and that group comprised 40 percent of the uninsured adults.

In every age category, men are more likely to be uninsured than women, with the exception of that group between the ages of 55 and 64. That age group is more likely to have coverage than younger groups, but women are more likely to be uninsured in that age group than men.

The characteristics of the uninsured will be an important determinant of the impact of health insurance reforms. Age and gender and to some extent income are good predictors, are important pre-

dictors, of risk. An income, of course, affects the ability and the willingness of individuals to purchase coverage.

Thank you very much.

The CHAIRMAN. Thank you, Dr. Custer, for an exemplary, succinct, informative and stimulating presentation.

[The prepared statement of Dr. Custer appears in the appendix.]

The CHAIRMAN. Dr. Helms, would you proceed, sir?

STATEMENT OF W. DAVID HELMS, PH.D., PRESIDENT, ALPHA CENTER, WASHINGTON, DC

Dr. HELMS. Mr. Chairman, distinguished members of the Senate Finance Committee, I have been asked to review the results of public/private partnerships which began in the late 1980's to expand health insurance to the working uninsured.

As you have heard, I am President of the Alpha Center, which is a nonprofit and nonpartisan center which provides policy and technical assistance to State and Federal Governments and Foundations.

I began serving as the National Program Director for the Health Care for the Uninsured Program in 1986, and now direct the State initiatives in health care reform program for the Robert Wood Johnson Foundation.

I reviewed the results in my written testimony. These are the results of very dedicated community leaders who have worked very hard to improve the affordability and accessibility for the health insurance for the working uninsured using voluntary, noncompulsory strategies.

It is important to understand the policy context in which these projects operated. The States were already fiscally strapped with funding Medicaid expansions and they were eager to find ways to entice employers to offer health insurance to their employees.

The projects worked in an environment with extensive medical underwriting, where that was the norm for small firms and their employees. There was certainly not the attention we have today on the health insurance crisis and the need for more comprehensive reform.

Today, policy makers must make a fundamental choice about how to expand health insurance coverage to the uninsured. Given that the majority of Americans currently get their health insurance through employers some believe that universal coverage could be achieved by encouraging non-insuring firms to purchase it for their employees voluntarily, thereby avoiding the need for compulsion or mandates.

This testimony reviews the results from the health care for uninsured program and other recent State programs, including in New York, California and Oregon, that tested the viability of an array of voluntary initiatives, including direct and indirect subsidies, tax credits, limited benefit plans—including very limited on "bare-bone" products—and buying cooperatives.

The results taken in the aggregate and compared to the magnitude of the problem were quite disappointing. But don't tell that to these who were able to obtain health insurance coverage through these subsidized programs. It is the proverbial glass half empty, glass half full.

So if we are not able to do universal coverage, I believe that the following minimal incremental steps must pursued: small group insurance reforms, voluntary health insurance buying cooperatives for the small groups, subsidies for low-income workers and their families, assurance of affordable individual coverage for part-time workers and others not covered by employer-sponsored plans and expansion of Medicaid coverage for all those up to 100 percent of the poverty level.

Policymakers should clearly understand that while more of the uninsured would be covered through these incremental steps, the goal of universal coverage will still not be achieved.

The critical question raised by these voluntary efforts to entice small employers to purchase health insurance for their employees is: Why do they not work? Some employers reported that they feared that State Governments would retract the subsidies when they faced hard economic times. I am sorry to report they were right, as evidenced by what happened in Maine, Michigan and Wisconsin when they withdrew the subsidies.

It could be argued that these projects did not test whether subsidies greater than 50 percent would achieve a better response. But this would be costly for the public sector and certainly for States alone. And from the experience outlined in this testimony, it would be disappointing as well.

The fact that these uninsured workers in small firms, as you have just heard, are primarily low-wage workers means that they will have to be heavily subsidized. Unfortunately, there is little evidence that voluntary efforts alone will close the gap.

These projects achieved a very small market penetration. Even with subsidies from 30 to 60 percent of the prevailing rate of insurance, these projects were only able to get a market penetration in the best case of about 17 percent of the uninsured small firms.

Universal coverage cannot be achieved voluntarily. This is why many States moved on to more comprehensive reforms.

While there are unique circumstances in each, the States faced a continued escalation in cost and ever increasing number of uninsured and a recognition that our employer-based system was breaking down—the number receiving coverage through that mechanism is declining.

But more important, the States realized that simply doing these incremental steps—e.g., Medicaid expansion, subsidized programs and small market insurance reforms—were not going to achieve the goal of universal access, which they, too, very much want to achieve. It is why they are looking at more comprehensive reforms.

I hope it is time in this country to make the commitment to universal access for the reason that it is simply the right thing to do. But it is also pragmatically the best way to make a system of managed competition work or to impose expenditure limits should that become necessary.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Dr. Helms. That is very helpful, specific experimental data, which is very important to this committee.

[The prepared statement of Dr. Helms appears in the appendix.]

The CHAIRMAN. As you say, States have been facing the dilemmas which you encountered and have moved to more comprehen-

sive arrangements, of which New York, I believe, is the first, sir, you tell us to establish community rating on a statewide basis. In any event, you have just done.

Mr. Curiale, we welcome you this morning.

STATEMENT OF SALVATORE R. CURIALE, NEW YORK STATE SUPERINTENDENT OF INSURANCE, NEW YORK, NY

Mr. CURIALE. Thank you, Mr. Chairman, and members of the committee. It is an honor to be asked to talk about New York's experiences in small group health insurance market reform.

You are very correct. In July of 1992, New York enacted community rating, open enrollment legislation which required all insurers, including HMO's who were writing insurance in the small group and individual market, to practice open enrollment, which simply is to take everyone and to rate on a community rated basis, which means you average everyone together. You do not vary in your rating on the basis of their age, their sex, their occupation or their health status.

The CHAIRMAN. Sir, could I just interrupt to thank you for something I hope we could encourage in these hearings, which is that the experts who know what they are talking about explain these terms. They are not instantly clear to everyone.

Community rating means everybody has the same price.

Mr. CURIALE. Rate.

The CHAIRMAN. Rate.

Mr. CURIALE. Price. Premium. Everybody is charged the same.

The CHAIRMAN. Premium is a bill, right? You get your premium in the mail. It is your bill.

Mr. CURIALE. That is correct, Senator. Unfortunately, sometimes these terms are used interchangeably and equally misunderstood on both sides.

Senator PACKWOOD. Can I ask a question?

The CHAIRMAN. Yes, Senator Packwood.

Senator PACKWOOD. Because I want to make sure I understand. You have two markets. You have a large employer market and a small employer market.

Mr. CURIALE. That is correct.

Senator PACKWOOD. Each of them are community rated, I take it.

Mr. CURIALE. No. The large group market tends to be experience rated.

Senator PACKWOOD. Okay.

Mr. CURIALE. But because of the size of the group, in effect if the group is large enough and you are rating it on its experience, it is averaged. So it is much more crucial to have community rating when you have small groups and individuals.

Senator PACKWOOD. In this small group, there is no variance, whether you are single or married, whether you have dependents or no dependents. You pay the same premium per employee.

Mr. CURIALE. Yes. You are averaged in with others like you. There is no variance.

Senator PACKWOOD. Now, wait a minute. "Others like you" or you are averaged in with everybody?

Mr. CURIALE. Everyone that has the same contract in the same geographical area is averaged in and you pay the same rate.

Senator PACKWOOD. Then I am confused. I thought you said this was statewide community rating. You have all of a sudden said geographic.

Mr. CURIALE. Yes. It is statewide, but it is definitely broken down into geographic areas. The insurers have different geographic areas which generally relate to at least the size of a county.

Senator PACKWOOD. Will you have different prices in different areas?

Mr. CURIALE. Yes, absolutely.

Senator PACKWOOD. So it is not State-wide community rating?

Mr. CURIALE. Well, you know, it is a matter of semantics. It is State-wide, but it is broken down in terms of geography. If I had had my druthers in terms of an insurance person, I would love to see State-wide community rating with the State being one community.

But you must recognize that there are different costs, expenses, facilities in different parts of the States. And politically, it is almost impossible to get the whole State to say, yes, we will be one community.

Senator, when you ask the question, am I my brother's keeper, invariably you get the answer no.

Senator PACKWOOD. Because I went to law school at NYU and I realize that Schenectady does not think of itself as New York City.

Mr. CURIALE. They do not think of themselves as the same community.

Senator PACKWOOD. I have a last question. I apologize for interrupting. Let us just say you——

The CHAIRMAN. No, let us get this clear.

Senator PACKWOOD. Now we are in the same geographic area, or Schenectady or whatever the area is.

Mr. CURIALE. Right.

Senator PACKWOOD. A 45 year old adult male who is chronically sick, who is married and has got seven kids, is it the same for a policy as a healthy 21 year old single person?

Mr. CURIALE. Yes.

Senator PACKWOOD. Okay. Thank you.

Mr. CURIALE. Because that 21 year old might have a child tomorrow with diabetes.

Senator PACKWOOD. No, I understand.

Mr. CURIALE. If he is lucky, he gets older and ultimately it is better for society if it is all in one pot. That is our view in New York.

The CHAIRMAN. I believe, sir, that this began in Monroe County with the City of Rochester, did it not?

Mr. CURIALE. Rochester is always pointed to as a great example of community rating. What makes Rochester so great is that the Blue Cross/Blue Shield plan there community rates, but the major employers in Rochester, rather than self-insuring, which might be to their benefit, have joined in the community and have put all their employees into the pot so that the law of large numbers, which all insurance is based on, the spreading of the risk, and there are other insurance principles like risk selection which we

think are abhorrent to health insurance coverage, but in Rochester I think it is Kodak and some of the other major employers, rather than self-insuring, have decided to join in with the Blues. That is why they have such a healthy community.

The CHAIRMAN. I do not want to take advantage of the Chair here, but could I just say to my colleagues, and I believe it is the case, sir, that Blue Cross/Blue Shield coverage in Rochester is two-thirds the average for the nation. And in no sense is it a skimpy arrangement at all.

Mr. CURIALE. Yes. And part and parcel——

The CHAIRMAN. Is that the case?

Mr. CURIALE. That is correct, Senator. And part and parcel of their success is that because this major employer takes part in the community pool of the Blues, they also take part in planning health care, in cost containment, and it is a very worthwhile situation there.

To go on, the law also provided for portability of pre-existing condition waiting period so that if you were insured with one insurer and changed to another insurer and you are continuously insured, and by that it is defined as being at least within 60 days you go to another insurer, you will not have to have another waiting period. Your pre-existing conditions will be covered.

This has cured job lock, the so-called phenomenon where people are afraid to change jobs because they are afraid that when they join a new insurer they will not be able to have coverage.

There is also in the bill—there are many other provisions, but I am trying to hit the highlights. There is a risk adjustment mechanism which attempts to convince insurers that they should be staying in the market. It adjusts risks based upon demographics—age, sex—and family coverage that different insurers have, recognizing that age and sex has a great influence on the morbidity and, therefore, the cost of the various pools.

It also has a pool which is based on specified medical conditions which include transplants, both organ transplants and bone marrow transplants, neonates, low-weight babies which are very, very expensive to treat, people who become dependent upon respirators and AIDS patients.

So what that tries to do is, since we are having open enrollment and community rating and since insurers have to take everyone, we have an adjustment mechanism which will prevent insurers from being adversely selected against and will attempt to balance out the pools.

What that also did was to——

The CHAIRMAN. Sir, I am going to ask, adversely——

Mr. CURIALE. Selected against.

The CHAIRMAN.—selected against.

Mr. CURIALE. Yes.

The CHAIRMAN. Would that mean—let us work that out.

[The following statement is purely a hypothetical example used to illustrate the concept of adverse selection. It is not meant and should in no way be interpreted to imply that New York Life has done anything improper.]

Mr. CURIALE. Here is what you have, Senator. Many of the companies that said, oh, no, we cannot have open enrollment and community rating said that if we had that what prevents, for example,

an ad being placed in the Village Voice by the Gay Men's Health Crisis. New York Life, for example, has been very, very difficult with us, refusing to take our groups. Now that we have open enrollment and community rating, everybody go to New York Life.

Therefore, you would call that an adverse selection. They all of a sudden might have very, very costly insureds. What this system tries to do is to account for that and to have a balancing factor where you will have pool set-up which are contributed to by all insurers, which will represent the demographics of the pool and also specify medical conditions.

The CHAIRMAN. Thank you.

Mr. CURIALE. To understand the impact of this law and the importance of the law, I think it is important to know what led up to it. During the 1960's and 1970's in New York we had a tremendous situation for small groups and individuals. Medical care costs, health care costs were not escalating at the rate that they are escalating today. Things were relatively stable.

Most people in small groups and individuals were covered by the Blues. They community rated. They open enrolled. The commercial carriers did not bother much with the small groups.

As the 1980's came along and health care costs started to escalate some of the small group carriers got a very good idea. They determined that by very carefully underwriting risk selecting and by experience rating small groups they could attract the healthier, younger groups from the Blues and essentially make a ton of money. They could give good claim service because there was not very much frequency or severity of claims.

Essentially, Senators, it was like shooting fish in a barrel. What happened eventually and into the late 1980's and into the early 1990's was that the once very well balanced pools of the not-for-profits, the Blues, which had lots and lots of young and healthy people, along with the older and sicker people supporting the entire pool began to be systematically stripped.

Now some people call that "cherry-picking," but you do not need to call it cherry-picking. It is a simple matter of economics. If you have one set of insurers that are permitted to underwrite and experience rate their people, that is take them if they think they are young and healthy, and then even if they turn out not to be because something happens to them, raise their rates, along side a system where you have not-for-profits taking everybody and average rating them, you will have a natural migration.

And as time goes by and health care costs go up, more and more the community rated pools of the Blue Cross/Blue Shield plans became more and more expensive. It was an upwards spiral that in 1990–91 reached—I hate to use this word—crisis proportions, Senator. It was a very, very serious problem.

What we had in our State was a separation of the young and the healthy from the older and the sicker, a separation of the lucky from the unlucky. What we did was to change that situation. We had several things happen.

I will take a little more time because you asked questions.

The CHAIRMAN. Please do. [Laughter.]

Senator ROCKEFELLER. You are meant to ask before you say that. [Laughter.]

Mr. CURIALE. What we had, I think we have now a situation in New York where we have health insurance more available and more affordable for all people. The younger people sent out a great hue and cry at the outset of community rating. There is no doubt that their rates went up.

If you have an averaging, it stands to reason that that is going to happen. But 60 percent of the people actually had lowering of their rates or rates that were not higher than 20 percent, which included trend, which meant that the trends were probably going to raise those rates a good deal anyway.

The people that got 100 percent increases were some young people, very young people, maybe 5 percent of the insured. Senators, they had "ice in the winter" anyway. They had experience rated policies. I call it ice in the winter. It was more appropriately called warmth in the summer, because they had an illusion. They had low rates while they remained young and healthy.

Once something happened their experience rate went up and they were bounced out to the Blues. The Blues now had them when they were expensive. The situation is much better now. We have rate stability. Naturally health insurance premiums are still very high because of health care costs. But I feel like we are on the right track.

We need other things. We need to have standardized medical packages so that companies cannot engage in back door underwriting. What that is is that a health insurer offers only products which appeal to the young and healthy—high deductible policies—and in that way they have open enrollment and community rating, but sick, older people do not buy their policies.

We also need an all markets bill. We need subsidization from the large experience rated carriers who do not insure the individuals, who are still relegated only to HMO's under our law.

Thank you, Senator.

The CHAIRMAN. Thank you.

[The prepared statement of Mr. Curiale appears in the appendix.]

The CHAIRMAN. As someone who is just this minute filling out his Medicare forms, could I suggest that not everybody is old and sick. [Laughter.]

And to say just for the record that the Superintendent did not in any way intend to suggest that the Gay Men's Health Crisis Center has adversely selected against anyone.

Mr. CURIALE. Absolutely, Senator. I am glad you clarified that.

The CHAIRMAN. They are a responsible and very helpful organization in what generally is a crisis. There can be no question.

I have interrupted enough already. Senator Packwood?

Senator PACKWOOD. So have I, Mr. Chairman, but I have a few more questions.

I want to make sure, Mr. Curiale, in your geographic, not Statewide, but geographic, community rating there is no difference in premium between family and individual.

Mr. CURIALE. Yes, there is a difference in premium between family and individual.

Senator PACKWOOD. Oh, there is?

Mr. CURIALE. Yes.

Senator PACKWOOD. Okay. Is that the only difference within a geographic area?

Mr. CURIALE. The community rating refers to no differences on the basis of age, health status, occupation, or sex. Naturally, there would be differences based upon benefits, if you have richer benefit packages.

Senator PACKWOOD. Wait a minute. The packages are not standard either?

Mr. CURIALE. The packages are not standard either, no.

Senator PACKWOOD. Oh.

Mr. CURIALE. And we need that.

Senator PACKWOOD. I agree. So an average person might have trouble comparing packages possibly if, there are different benefits?

Mr. CURIALE. And that is one of the problems.

Senator PACKWOOD. Now I want to come back to the community rating as to conditions. Forget the difference in the benefits. That I understand. Apart from family versus individual there is no difference in the rating within the community.

Mr. CURIALE. That is correct.

Senator PACKWOOD. Okay. Now then, let me find Dr. Helms' testimony here. Doctor, you say very boldly, and it is in the first page of your testimony, if the goal is to achieve universal coverage, voluntary approaches to making health insurance more affordable and available will not be sufficient, i.e. they do not work.

Dr. HELMS. That is right.

Senator PACKWOOD. Do you agree with that, Dr. Custer?

Dr. CUSTER. Yes, I do.

Senator PACKWOOD. Mr. Curiale?

Mr. CURIALE. Yes.

Senator PACKWOOD. Is there anyway we can get to universal coverage then without compulsion?

Dr. HELMS. I think we have tried everything we know. As Sir Winston Churchill said, "Americans can be counted on to do the right thing after they have exhausted all of the other possibilities."

Sir, I believe that through these demonstration programs which began in the late 1980's that we tried everything we could short of making coverage compulsory. We used very high cost sharing. We used all kinds of subsidy arrangements. Our results demonstrate that simply trying to entice employers to purchase insurance through offering less benefits or providing subsidies will not get you to the goal of universal access.

Senator PACKWOOD. The other two of you agree?

Dr. CUSTER. Yes, Senator, I agree. One of the reasons I think universal coverage is important rather than universal access is what we see in the State of New York and have seen. Is that people drop in and out of the system. It is not only because you want to cover everybody and everybody deserves coverage, but you have to have everybody in the system because people will stay out of the system while they think they are young and healthy and only drop in later when they feel that they——

Senator PACKWOOD. I have other questions. Do not answer more than I need. [Laughter.]

The CHAIRMAN. And do, please, remember, there are lots of old and healthy. [Laughter.]

Senator PACKWOOD. You all three agree that—I will use the word compulsion; others would say mandates—but short of some method of enforcement we are not going to get universal coverage. It is not going to come through tax incentives. It is not going to come through wishes.

Dr. CUSTER. Yes.

Dr. HELMS. Yes.

Mr. CURIALE. Yes.

Senator PACKWOOD. Okay. Next, the issue of community rating and the argument that, well, if we go to community rating—you come very close to it apparently in these small market areas in New York, apart from family versus single—how do we rebut the argument that if you go to community rating there is no incentive for good health, that the employer is paying the premiums as well? Why should I try to get my people to quit smoking or why should I have a P.E. program? It does not make any difference. I have to pay the same rate anyway.

Mr. CURIALE. I think just the overall—it is the same rate, but the overall costs for everyone keeps going up and going up.

Senator PACKWOOD. I understand that. But an employer who works at it and really—and an individual who works at it, does not smoke, does not drink and works out gets no better break than somebody who is an absolute drinker, smoker, does not exercise. Where is the incentive?

Mr. CURIALE. Senator, we did a study on wellness incentives because part and parcel of our community rating, open enrollment law, the legislature required us to do so. The problem with those incentives first of all is that there is no guarantee. You can ask Jim Fix who ran judiciously and died of heart attack. There are plenty of people that do not smoke that get lung cancer.

Senator PACKWOOD. Wait a minute. Wait. But on average.

Mr. CURIALE. Yes, that is true. But the other problem in terms of a regulator and trying to make the system work is, it is almost impossible to enforce. It is impossible to see whether or not a person is smoking. It is impossible to see whether or not a person is jogging every day. It is impossible to see whether or not a person——

The CHAIRMAN. Not if he is President of the United States. [Laughter.]

Mr. CURIALE. Other than the President of the United States, Mr. Chairman, I would say that our studies of the situation have been that unfortunately it is not enough of a predictor of good health and low cost and it is almost impossible to enforce.

Senator PACKWOOD. Let me ask Dr. Helms and Dr. Custer. Do you agree with that conclusion, and we ought to go to as broad a base of community rating as possible and realize in essence we will quit experience rating even within the community?

Dr. HELMS. I generally accept that that is what is going to be necessary, yes.

Senator PACKWOOD. Dr. Custer?

Dr. CUSTER. In our studies of employer sponsored wellness programs, health costs were one of the lowest reasons, ranked reasons, for offering those benefits. There are productivity reasons and mo-

rale reasons and good work force issues why employers would want to offer those programs that have little to do with health.

So I do not think that a community rate would reduce the incentive to offer those benefits.

Senator PACKWOOD. Thank you very much. Very helpful.

The CHAIRMAN. Very helpful, indeed. Thank you, Senator Packwood.

Senator Baucus?

Senator BAUCUS. Thank you, Mr. Chairman.

I would like to follow up a bit on Senator Packwood's questions. Again, I hear you all say that as wide of community group as possible makes the most sense. Second, I hear each of you say that some form of compulsion is necessary. Is that right? I see all heads nod.

Dr. HELMS. Yes.

The CHAIRMAN. The record does not show nods. [Laughter.]

The CHAIRMAN. Dr. Custer, Dr. Helms and Mr. Superintendent, you say yes?

Mr. CURIALE. Yes.

Dr. CUSTER. Yes.

Dr. HELMS. Yes.

The CHAIRMAN. You agree.

Senator BAUCUS. What form of compulsion do you think makes the most sense? Some suggest individual mandates and some suggest employer mandates. What do you think is the best way to get at this question of how you most efficiently include this large group of the American population, basically everyone?

Dr. CUSTER. EBRI, of course, does not take positions on what would be best or worst. But I can tell you that there are different affects of an employer mandate versus an individual mandate in the short run. In the long run, economic theory will tell you that you are spending the employee's money. The differences in the long run will not be there.

In the short run, the markets cannot adjust fast enough to have that be the individual's money. In the short run, if you go through an employer mandate, you will affect the labor market. That will mean that in the straight mandate the way that was suggested 2 or 3 years ago by the Senate, the majority with no cap on the percentage of payroll, you will have some job losses.

Senator PACKWOOD. Okay. Dr. Helms?

Dr. HELMS. I guess the first answer, I would certainly support the idea that in the long run this cost does get shifted back largely to the employees. It is why many States who impose this mandate—Oregon has pushed its out a few more years; Washington ultimately for the most affected group, has a mandate of 1999. This gives some time for the employers to adjust and prepare for the imposition of the mandate.

My own personal view, which will not be terribly enthusiastically received here, is that it would be more efficient to do this through a tax financed system. I happen to like an individual mandate as a way to impose this burden. But that requires, in my opinion, your moving to a tax-financed system.

Senator PACKWOOD. Mr. Curiale?

Mr. CURIALE. This is just a personal viewpoint. I think a combination of employer and individual mandate is necessary with tax supports, taxpayer subsidies. I think that the participation is necessary for the purpose of having cost control, for the purpose of having everybody have a stake in it. I think it would lead to ultimately everyone feeling the pain of high health care costs and, therefore, participating in the sacrifices that are necessary to hold them down.

Senator BAUCUS. That gets to my next question. I mean, assuming we want some kind of universal coverage and assuming further some form of compulsion is necessary to get there, there is another big unanswered question that is cost.

I assume that in New York and in all States that have insurance reform insurance is still very costly for a lot of people. And even under the voluntary system in New York, I assume a lot of people just do not buy insurance because it is too expensive.

So how do you deal with costs? Particularly because there are just so many people who just are not in the system because it is so costly for them.

Dr. HELMS. Senator, I think it is important to recognize the vast political differences that exist within our States—their political cultures, their willingness to use government intervention.

One of the things that has attracted me about letting States experiment around the cost issue is that some very much want to try the concept of managed competition. Others to continue to use the rate setting systems that they have built over time. And several are even building, as in Minnesota, at least an ability to effectively monitor the growth of health care expenditures; or in Washington and actually imposing an overall expenditure.

Whether we have to ultimately impose an expenditure cap will be an empirical question of whether "managed competition" can will limit costs without also having to impose an explicit expenditure limit. Clearly, we must obtain much better information on a statewide basis to monitor and, if necessary control costs.

Senator BAUCUS. Dr. Custer, how do we make insurance sufficiently available from a cost basis to small businessmen and employees and other individuals?

Dr. CUSTER. The issue of cost in an insurance market depends upon the pool, the risk pool, as we have already heard. If you are going to lower the costs to small employers, you have to include them in a pool that includes more of the healthy individuals.

One of the problems or issues with community rating is that you are bringing poor risks into the pool. If you do not also augment that with the better risk, you are going to have higher prices as we have seen.

Senator BAUCUS. The cost can still go up.

Dr. CUSTER. The long-term trend for national health expenditures——

Senator BAUCUS. That is my question. How do you deal with the cost? How do you deal with cost?

Dr. CUSTER. That will not be directly affected in the short run by the insurance market.

Mr. CURIALE. Senator, I think that we are all dealing with costs and I think the escalation of costs has certainly made everyone

concerned with how to keep them down. I think what this has led to is a preoccupation with managed care right now, although there is certainly a lack of confidence, I think, by the American public in managed care, whether or not there are too many trade-offs in terms of quality and choice.

But I think that the costs are necessitating employers and individuals making those choices and we will see whether or not we can have an effective managed care system.

Also States like New York are emphasizing primary care to try and prevent the greater expenses later on. We are trying to keep people out of emergency rooms. We are trying to do all these things necessary to hold costs down.

Senator BAUCUS. One real quick question. So are costs increasing in New York, even with universal coverage?

Mr. CURIALE. Even with open enrollment and community rating, they are certainly increasing all the time.

Senator BAUCUS. At about the same rate as other States or not?

Mr. CURIALE. Probably more.

Senator BAUCUS. Thank you.

The CHAIRMAN. Thank you, Senator Baucus.

I hope we could all pay attention to Dr. Helms' remark that the different States have different political cultures. That is one of our——

Dr. HELMS. And different capabilities as well.

The CHAIRMAN. And different capabilities. It should not be forgotten. About 2 years ago, I demonstrated with devastating accuracy that if you want to improve your State test scores for 11th grade mathematics the easiest way, there is only one way to do it and that is move your State closer to Canada, as in the case of Montana. Other than that, there does not seem to be any other way to get this done. [Laughter.]

Senator Chafee?

Senator CHAFEE. Thank you, Mr. Chairman.

Mr. Curiale, the bill that I have co-sponsored with 19 of my Senate colleagues applies adjusted community rating—we have a variation on age only, not sex, just age—to groups of 100 or less. What are the down sides of applying that to larger groups as well?

Are there complexities in managing this? Maybe we ought to just apply it to everybody, but we just did it with 100 or less, feeling that those were the companies with the problems—100 or more it works out as you said it does.

Mr. CURIALE. Senator, we did it with 50 or less, only because traditionally in our State that is what the companies considered to be small groups. The larger the better in terms of insurance principals. If we could have done it with regard to 100 or 200 and got it passed in our legislature, we would have done it.

Again, the maximum spread of risk is what makes it better for everyone. Also, what we would like to do ultimately is to have the large group, all large groups, including self-insureds, participate in the risk sharing through risk adjustment mechanisms.

Senator CHAFEE. So the only reason you did not apply, you just did it for 50 or less, the only reason you did it was political, getting it through the legislature?

Mr. CURIALE. That is correct.

Senator CHAFEE. Okay. Well, the larger the better, but if you cut off at 100 or less, does it make much difference?

Mr. CURIALE. Well, I think what you are going to do is you are going to cure the worst problems if you cut it off at 100 or less; or if you are at at least 100, because it is with regard to the small groups where you have two or three illnesses that occur and if you have experience rating that will create unaffordability in terms of your health insurance.

So if you do it at 100, you will be very effective; not as effective as if you did it at 200, not as effective as if you did it at 5,000.

Senator CHAFEE. Okay. The next question to everybody here. Is this business of risk adjustment a pretty exact science?

Mr. CURIALE. Not at all. And, in fact, we have been criticized in New York because our system is too simple. But we figured we would start simple with a demographic pool and with a specified medical condition pool and we would develop from there. It is not an exact science at all.

Senator CHAFEE. It would seem to me to be a very, very tricky business. How you do it without penalizing somebody rather severely I do not know. How painful is it, Dr. Custer?

Dr. CUSTER. Well, you are right. It is not an exact science and I do not see a good way to create a risk adjustment system that cannot be gamed by some participants in the market or maybe create some equities.

Senator CHAFEE. The final question if I have time.

The CHAIRMAN. No, there is plenty of time.

Senator CHAFEE. We have a provision in our bill which opens small group plans to individuals and individual plans to small groups. What would be the effect of an all markets requirement on the industry?

Mr. CURIALE. I think it would certainly benefit everyone. I think, again, when I say benefit everyone——

Senator CHAFEE. The question is, just so everybody gets it, that every company has to take everybody. Some companies, I think Mutual of Omaha, did they not really specialize in taking individuals?

Mr. CURIALE. Yes, but they specialized in high deductibles and under wrote in a situation where they were getting younger, healthier, low risk people.

Senator CHAFEE. I am not——

The CHAIRMAN. Those young and healthy people.

Mr. CURIALE. Sorry, Senator.

The CHAIRMAN. It sounds like Bing Crosby.

Mr. CURIALE. That is what the insureds want, Senator. They want those young, healthy people. [Laughter.]

Senator CHAFEE. They are very attractive. [Laughter.]

Mr. CURIALE. Those, too, Senator. [Laughter.]

Senator CHAFEE. I want to echo what the Chairman said, every old person is not sick.

Anyway, what is the effect? Do you believe in this; every company must take everybody? I would like to ask Dr. Helms the same question.

Mr. CURIALE. We have an all markets bill. If you do not take everybody and you do not insure or write contracts for individuals,

we believe that you should participate in a risk adjustment mechanism and subsidize in some part those companies that are willing to write individuals.

Individuals, people that buy insurance as individuals, tend to be riskier people. They are not buying in a group context. Many of them——

Senator CHAFEE. Okay. Thank you. [Laughter.]

Dr. Helms?

Dr. HELMS. I think I can be mercifully brief on this issue. We do not have a good system of risk adjustment. We have research underway now, some of it sponsored by foundations and by the Federal Government to develop a better risk adjustment system.

The State of Washington which has established a managed competition system for their employees, and are now expanding this mechanism to include their Medicaid population and those who receive coverage through their State-subsidized basic health plan. The Washington State Health Authority which operates this system is now testing a new risk adjustment mechanism which may be helpful.

You may need to do a back end reinsurance process.

The CHAIRMAN. Stop right there—back end reinsurance.

Dr. HELMS. Let me define these terms. Reinsurance is a mechanism for spreading high cost cases after costs have been incurred. With risk adjustment, the potential costs are assessed before care is provided and the rates are adjusted accordingly.

For the reason why health policy people do not want you to do it on the back end is that you take away an incentive to get the insurers to do a better job of managing the cost of those very high cost cases.

Senator CHAFEE. Good. Thank you very much.

The CHAIRMAN. Dr. Custer, did you want to respond to Senator Chafee.

Dr. CUSTER. David Helms did a fine job. Thanks.

The CHAIRMAN. Thank you, and thank you, Senator.

Senator Rockefeller?

Senator ROCKEFELLER. Thank you, Mr. Chairman.

I just wanted to say philosophically that as we do this—and the Chairman has mentioned on a number of occasions the need to get, you know, a certain number of votes. We obviously have to have the votes to pass this.

But listening to these three gentlemen testify it again makes it so clear that we have to reform a health care system in such a way as it will work. We cannot do it and then find we have made seven major mistakes and come back in 3 years and expect to do a very good job. We have to do it right.

So this is not just about ideology. This is not about winning or losing. It is about making a system that will work.

Mr. Chairman, I would note incidentally how long we have come. A couple of years ago the Finance Committee reported out small group insurance reform legislation that allowed a 900 percent variation in premiums based upon age, sex, and other factors.

I think limits then were targeted only to the small group market defined as being under 50 or under 25. Now virtually everybody is at 100. Blue Cross/Blue Shield, which is going to testify later on

that the reforms should apply to at 100 or less. They were at 25 2 years ago. So there is a lot of progress being made. We are getting a lot closer on insurance reform.

One question of Dr. Custer that I simply have to ask, because a moment ago you said with no cap on the percentage of payroll, you will have some job loss. What makes me address that is any time you say the word "job loss" around here, all antennae go up.

The Alliance for Health Reform recently participated with you, with a fellow from MIT, and another scholar from the University of Alabama, all representing three different points of view. If I recall correctly, all of you agreed that if mandates were applied that there would not be—the so-called job loss situation would be a wash.

There was no disagreement between the three of you as I remember and there was strong agreement that the woman who had said there would be 3 million jobs lost, that neither the Clinton plan, nor the Chafee plan, nor anything else was factored into her thinking. Am I right about that?

Dr. CUSTER. That is correct. I was cut off a little bit before I could—as you know, we spent an hour and a half on that instead of the 2 minutes I had to respond there. I was trying to make the distinction between what happens in the long run and the short run. As I said at that meeting, in the short run—and again, David Helms mentioned—that if you transition a mandate in, an employer mandate in, the employment effects are mitigated in the large extent.

In the short run, you can have some job loss; in the long run, all those effects go away. That is where you get the employer mandate, individual mandate having very similar effects on income on jobs and a variety of other areas.

Senator PACKWOOD. Jay, run that by me again, because I think I grasped it. I think it is important. But I want to make sure. Tell me the point you are making.

Senator ROCKEFELLER. The point I am making is that we, in this alliance, which is a nonprofit group I started after the Pepper Commission just to push health care. It is not pro-Clinton or pro anything else, it is pro-reform.

The idea is that the idea of job loss is so galvanizing to so many people that they never get beyond it.

Senator PACKWOOD. And is the point that without a cap there will be job losses?

Senator ROCKEFELLER. No.

Senator PACKWOOD. Okay. That is what I am confused about.

Senator ROCKEFELLER. The point is if you have a mandate——

Senator PACKWOOD. Right.

Senator ROCKEFELLER [continuing.] Which is the "m" word, that it is basically a wash with respect to job loss.

Senator PACKWOOD. Okay.

Senator ROCKEFELLER. You have some in the short term, you pick up in the longer term. But they all—MIT, University of Alabama and Dr. Custer from EBRI—indicated it is basically a wash.

Senator PACKWOOD. With a mandate?

Senator ROCKEFELLER. With a mandate.

Senator PACKWOOD. All right. Thank you.

Senator ROCKEFELLER. My only question—I do not even have time for that—if you could each repeat clearly, as you have stated, why a voluntary system of participation does not bring universality.

Dr. CUSTER. As I said in my testimony, a good portion of the uninsured are both young and low income. Young, excuse me, means that they are fairly healthy risks. The idea of purchasing an insurance project——[Laughter.]

You may not need it when you have low income and have a variety of other uses for your money, it is low on priority. So without a compulsion, a number of Americans will choose not to buy health insurance. It will be a rational choice for them. And they will predominantly be the best risks.

Dr. HELMS. Senator, I have said it will not work because experience has demonstrated over and over again that it will not work. Employers do report that the number one reason why they do not provide coverage for employees is cost——

They also report that employees can be hired without providing health insurance and that their employees are insured elsewhere. That is why large employers are interested in mandating coverage because they are paying for these employees in small firms through spousal coverage in the system of free-riding that we have currently.

Mr. CURIALE. Senator, I would simply add that you cannot have a system where people are allowed to drop in and drop out depending upon how they perceive themselves as risk.

Senator ROCKEFELLER. And is it not true that——

Senator CHAFEE. Could I interrupt once more? When you are referring to "it will not work," what will not?

Dr. HELMS. In my testimony——

Senator CHAFEE. A voluntary system, is that what you are talking about?

Dr. HELMS. Yes, sir, subsidies. Voluntary subsidies will not entice a substantially enough proportion of the working uninsured to receive coverage.

Senator ROCKEFELLER. Well, in other words, that subsidies——

Dr. HELMS. Do not do it.

Senator ROCKEFELLER.—will lead to a voluntary reaction as opposed to a full participation.

Dr. HELMS. Right. Yes.

Senator ROCKEFELLER. And is it not true that there have been a number of studies, in fact, which have taken small businesses and have given them up to 50 percent subsidy of their health insurance premiums and that as few as 3 or 4 percent of those—these are small businesses—even with those subsidies went ahead and bought insurance for their employees?

Dr. HELMS. And, sir, this is the research that I have presented in the written testimony, sponsored by the Robert Wood Johnson Foundation. We tried lots of different things and we got a very small market response.

Senator ROCKEFELLER. That just needs to be very clear on the record.

Thank you, Mr. Chairman.

The CHAIRMAN. And it now is, which we thank you.

Senator Durenberger?

Senator DURENBERGER. Mr. Chairman, thank you very much.

First, this is an excellent panel.

Second, I made the mistake of scheduling my Minnesota Hospital Association right now. So the next excellent panel, Bill Gradison and Mary Nell Lehnhard and Bill Link, I apologize to in advance, as I do to you, Mr. Chairman and my colleagues.

Third, it should be plain by now that what we are doing is not health reform. This has nothing to do with health reform, except indirectly. All we are talking about here today is insurance reform. Okay? And all these other issues about how do we get it to everybody and all the rest of that sort of thing, that gets into equity issues like how many people do you want covered in what way.

But it is really critical to begin with the notion, we are just talking about a system which has been run State-by-State, sale-by-sale, company-by-company where the only issue is solvency and occasionally the way you price. And people like you all have struggled with trying to make it better and we are trying to fix it by raising it up here to the national level to make it work better. That is the first point.

Second, that each of you has talked about the quality of information. Much of the experience, much of the learning curve on all of this has been in basically dysfunctional marketplaces.

So nobody—New York, Minnesota, nobody—has a perfect market in which we can take this information you are giving us and translate it into something that will last for the next 10 years. It is valuable, but it is not necessarily predictive.

Third, that when we talk about community rating or adjusted community rating or whatever it is, we are basically talking about the price of a product. We are not talking about the product.

The product is what produces costs. If you want to buy a product that keeps you healthy, diagnoses you correctly right off the bat, puts you back to work more quickly, then you have to change the delivery system, which this is insuring. And we are not at that in the current system.

We are just talking about the community rate or an adjusted community rate for a product that we assume maybe it changes, maybe it does not. However, it is important to look at community rate or adjusted community rate, because one of the ways in which equity through our policy makes whatever the product is affordable to more people is the way in which we subsidize that price for various people.

To the degree that we use community rating or any rating system to ask the healthy, young, male, whatever it is, to subsidize the old, sick, female, or whatever it might be, that is a very explicit decision that is taken community-by-community, State-by-State, however you define community. I mean, we could even do it with a national system.

There are well documented cost differentials between people in these various categories, even though we may joke about the health of the people on this committee. But anyway, it is a very specific choice we make, just like the choice we make to ask all employers to pay such and such a percent of premium. That is an explicit subsidy; or, the tax subsidy, that is an explicit subsidy. Each of which

is designed to make the price more affordable, but as yet does not have much to do with the product.

So I needed to reinforce that, Mr. Chairman, and make a comment about the role of the employer in all of this. It depends on where you are in terms of how you assess the role of the employer.

It is important in my community as I watch change to see that the employer's contribution to the premium makes a difference in what plan the person selects. If you make 100 percent contribution to this plan and an 80 percent to that one or, you know, you pay 80 percent to both but you are willing to pay 80 percent of a high price and 80 percent of a low price, that makes a difference. That is called elasticity of demand or something like that. [Laughter.]

That is important. Conditioning the contribution on behavior, making choices among plans, that is an important employer contribution. In many companies in my State people are beginning to work with their employees on life style, on a variety of other things. So that is an important role of the employer. It is not one that government does a very good job of—you know, ordering people to behave in certain ways.

To get to my questions, and I have two. One of them is, in my State we went to small group insurance reform July 1. The market was 2 to 29. Employers were required to pay 50 percent. Just so you understand that part of it. And they were required to have at least 75 percent of the employees in the group. Otherwise, it was all the same. Rating bans were 25 percent, except for gender, which they eliminated gender as a factor and things like that.

Here is what happened in my State, just using Blue Cross/Blue Shield of Minnesota. The Blue Cross/Blue Shield sales in 6 months went up by 230 percent in that small group market—230 percent.

Much of that was in the non-urban rural areas that have traditional barriers to access because people are always being experience rated in their small groups. The other factor was that 49 percent of the groups which Blue Cross/Blue Shield sold since July 1 never had coverage before.

Dr. HELMS. Could you restate the percentage?

Senator DURENBERGER. Forty-nine percentage did not have coverage before.

So is that an anomaly and if so, maybe you can tell us why it is an anomaly, Dr. Helms.

Dr. HELMS. Sure.

Senator DURENBERGER. But it seems to me that is responding to a real need.

Dr. HELMS. Yes, sir. I said in my testimony that operating these subsidized products in a reformed health system might have yielded better results. But the experience in California—referred in my written testimony shows that for firms with between 5 and 50 employees that only 22 percent of the newly insured there were previously uninsured.

Our projects set out as their target audience to get those that did not have insurance before. A lot of times when we open these systems up to firms which have been previously insured are going to see a better deal and move into the pool. The question I was addressing in this testimony is whether or not people who have been previously uninsured will come in, if with voluntary polling ar-

rangements along are used. The experience to date is that this is a "tough sell" in this market.

Senator DURENBERGER. We did not add to the subsidy in Minnesota. You got 49 percent new business without——

Dr. HELMS. That is good. I am saying that is good. That is better than we have seen typically when that alone gets done. But that is good.

Senator DURENBERGER. Thank you.

Dr. HELMS. Minnesota also, sir, has one of the smallest proportions of our uninsured in the country. You are at 8 percent. Do this in a State where the uninsurance rate is 20 or 25 percent and it is a tougher sell.

The CHAIRMAN. It is the iron law—move close to Canada. [Laughter.]

Senator Grassley?

Senator GRASSLEY. Thank you, Mr. Chairman. I want to talk about community rating in New York. Some people argue—and also I think specifically people in the administration have argued—that it is not going to work without a strong regulatory body to enforce it because insurers are going to find some way of getting around the requirement.

So what has been the experience in New York with respect to compliance by insurers?

Mr. CURIALE. Well, there were dire predictions that the companies that were writing small group insurance were going to leave the market, but they have not come to pass. They are complying with community rating and open enrollment.

We still have a problem with regard to the individual market because our law did not require companies, insurers, to offer indemnity coverage to individuals. It required HMO's to offer coverage to individual contract holders.

As I said before, typically individual contract holders tend to be the types of people that do not want to go to an HMO. They would rather have indemnity coverage. They would rather have choice of their own physicians.

We have seen that companies are complying with open enrollment and community rating and we are very much encouraged by it. We think that it has to go further. We think that we have to find a way somehow to get the large group carriers involved so that we can spread the risk even further.

Senator GRASSLEY. People were surprised that it did not happen. Would that apply to you, too, personally from your position? Did you think there would be less cooperation than ended up being?

Mr. CURIALE. Well, you always expect companies, certain companies, to try and what they call game the system, to put the applications for insurance on the 55th Floor and to not have the elevator running.

But what we have, this risk adjustment mechanism obviates that, because in addition to a requirement of community rating and open enrollment we are now testing the demographics of your company. We are going to take a look at your mix and see whether or not you still have only younger, healthier people, whether or not you have your share of higher risk people.

And if you do not, you are going to be paying into the pool. So this is an incentive for companies to do the right thing.

Senator GRASSLEY. You have noted that there have been several legal challenges to risk adjustment pools. Could you tell us briefly what the basis of those complaints might be? Then also, could you just on a little different angle, could you tell us about the political response to the overall reform more generally, particularly among those who experience higher premiums than they otherwise would?

Mr. CURIALE. Yes. There have been political challenges. The HMO's who typically have a younger mix of people have objected to the pooling mechanism. They have tried to argue that they are not insurers within the framework of the insurance law. That is subjudious and I think we will win on that; and if we do not, we will pass legislation to bring them in.

As far as the political response, yes, there was a hue and cry from the younger people at first. But I think that has died down considerably. I think they realize that they now have a stable product that they can depend on. They do not have to worry about leaving their jobs and not having insurance; and they also do not have to worry about illnesses in their families when they get older.

Senator GRASSLEY. Did you find a high percentage of young people dropping their insurance because of that?

Mr. CURIALE. We found some, but we did not find the types of dire predictions to come true, that people were going to drop out of the market. I think people recognized that the prices that they were paying before were just unrealistically low, and that the product that they were getting was not the product that they needed.

Senator GRASSLEY. You noted that there is going to be proposed in your State a standard benefit package legislation. Is your Department going to be making any recommendations and would you do it from the standpoint of a single plan for everyone or a variety of model plans? Could you also tell me why standard benefit legislation is needed from your perspective?

Mr. CURIALE. Well, it would not be one single plan. It would be a number of plans. And, of course, we would work with the Department of Health to fashion and consumers to fashion what that would be.

What you need to have is, you need to have a minimum standard package that is offered by every company, again, to prevent what I said before, referred to as back door underwriting. If companies are complying with the open enrollment community rating law, but they are only offering one product that has catastrophic coverage alone that has high deductibles, then they are not going to be getting their fair share of the sicker people, the higher risk people. And they need to be spread out amongst the population; they need to be spread out amongst all insurers.

Senator GRASSLEY. Dr. Custer, your statement noted a 21 percent increase in the uninsured between 1989 and 1992 and it occurred in those families in which the family head worked for a firm of 500 or more. Of course, your general point, I think, is that the most serious problems are among the small firms.

But it seems to me that a 21 percent increase seems a pretty large percentage for firms that we are assuming is going to do a pretty good job at getting insurance for their employees.

Dr. CUSTER. Well, that is right. The uninsured are not a homogeneous group. There are a variety of different reasons for people losing coverage. That number occurs because the majority of workers work for firms that large. So even if a few employers are dropping coverage or a few employees lose coverage, the percentage is going to be high and the number is going to be high.

So it is just where the people is why that number is large. I think the health insurance market discriminates against small groups and small employers and there is a definite policy issue there.

It is the case though that employment-based insurance coverage is eroding for all employment sizes.

The CHAIRMAN. Thank you, Senator Grassley.

Could I note with respect to your question about the changes in rates in New York and the response—I hope this does not imply that I do not hear young people enough—but as a New Yorker I have not heard the issue raised. I heard the statement that it would happen and then I believe it did not. Is that not about what you would say, Mr. Curiale?

Mr. CURIALE. Yes. As I said before, Senator, the rates actually went down or did not rise measurably for 60 percent of the people. Naturally, if you are averaging people together, there are going to be a small percentage of people that go up a great deal. But again, the product that they got is a lot better.

The CHAIRMAN. Thank you.

Senator CHAFEE. Mr. Chairman?

The CHAIRMAN. Yes, sir.

Senator CHAFEE. Could I just say one thing? There was a dialogue with Senator Rockefeller and the gentlemen on the panel, about whether you can voluntarily get people to get coverage. Dr. Helms was addressing that subject in the efforts of subsidization and so forth not working.

I just want to make clear that speaking for our program, it is not a voluntary one, it is an individual mandate. So I do not want anybody to go out of here thinking that what was said was directed toward the program that I and others are sponsoring. We require that individuals have the insurance. It is not a voluntary program.

Thank you.

The CHAIRMAN. The Chair rules that nobody will go out of here thinking otherwise. [Laughter.]

Senator CHAFEE. Thank you very much.

The CHAIRMAN. And now for the last questions of this excellent panel, Senator Daschle.

Senator DASCHLE. Thank you, Mr. Chairman.

It is an excellent panel. I have enjoyed your testimony and appreciate very much your answers to many of the questions. I was going to pick up where Senator Chafee has just left off.

I think your testimony clearly has indicated that there is a significant degree of advantage to a mandated system. As we look at the infrastructure of health insurance, our goal on this committee is to try and create the most efficient and effective way to achieve universal coverage.

As this panel has endorsed the efficacy of mandates, then the question is, which is most effective, an employer-based or an individual-based system?

We have differing models out there. We have auto insurance, an individual-based system, and we have mandated programs requiring participation by employers. Can we conclude from what is already in place which is the more effective and efficient?

Mr. CURIALE. I would like to say, I am not an expert on this, but since we already have basically an employer furnished health insurance system, certainly that would be the easiest one to implement, along with other additions to it, perhaps, to supplement it.

But I think that the main attraction of it is it is there.

Dr. HELMS. Even in an employer mandated system you have to have an individual mandate. The question, which really must be answered is going to pay for it. As I have already argued——

Senator PACKWOOD. Why? Is that for the people who are not employed?

Dr. HELMS. Yes.

Senator PACKWOOD. All right.

Senator DASCHLE. That is not the only question though, Dr. Helms.

Dr. HELMS. You were asking what is the most efficient way of doing this. If efficiency were the only objective criterion, then my answer would be to have the national government finance this. You could put on the pay stub that this is a health premium "tax."

But that is a hard sell because Americans have been taught to believe that employers are giving them health insurance when in fact, it comes out of their total compensation.

If you ask me on efficiency grounds alone, I would say let us let the national government finance this. But there would still be a number of questions to be resolved, such as how we distribute their benefit and how we effect a system of cost controls, et cetera.

Senator DASCHLE. I have two other questions. Dr. Custer, do you have anything to add?

Dr. CUSTER. Yes. I will just be brief. An employer mandate will not bring universal coverage and the costs that you get will depend upon how you define a worker, principally how you deal with part-time workers. But if you are dealing with full-time workers, you are going to have—I have this estimated but not with me—at least 12 million Americans without health insurance.

Senator DASCHLE. But that is not what I was asking. Can you directly answer which of the two is more effective?

Dr. CUSTER. Well, now you are talking about efficiency, who bears the costs. As we had a discussion earlier, the difference between an individual mandate and an employer mandate in the long run there are not going to be a lot of differences in who bears the costs. It comes out of the individual's money, whether they write the check or the employer does.

Senator PACKWOOD. Yes, but that still is not his question I do not think.

Senator DASCHLE. That is not my question. From a monitoring point of view and from an enforcement point of view, do we know which of the two models would be more effective based on our experience to date.

Dr. CUSTER. It is going to vary by employer and employer. Large employer, clearly yes.

Senator DASCHLE. There is another point you are very capable of addressing and I would like to have the advantage of your thinking on this.

Considering the relationship between the size of the pool, the level of risk, and the cost of premium, it would seem to me counter intuitive to say that the smaller the pool the smaller the risk. It would seem just the opposite—the larger the pool the smaller the risk and, therefore, the greater the ability to reduce the premium. Is that correct?

Mr. CURIALE. Yes. The costs are the same, but the larger the pool the greater the sharing.

Senator DASCHLE. Right.

Mr. CURIALE. When you have small pools and you have a limited number of sicknesses the premiums go up for everyone. What you want here is the maximum sharing of risk.

Dr. HELMS. Agree.

Senator DASCHLE. No disagreement there?

Dr. HELMS. No.

Senator DASCHLE. Finally, is there a way to eliminate the possibility of adverse selection and risk adjustment with voluntary alliances? Can you deal with what would be gaming the system if you were to allow that kind of an infrastructure?

Dr. CUSTER. And again, it is defining the risk pool. If you define the risk pool as employment based coverage alone and deal with the unemployed and low income as a separate population, you can have a risk pool that is going to be really comparable to what we have now.

If you bring in the people who are presently excluded from the employment based coverage, you are bringing in people who are predominantly poorer risks and then you have to find a compulsion way to keep people in.

Senator DASCHLE. Can anybody give me a short answer to that question?

Dr. HELMS. I sincerely think that the answer you have been given is correct.

Senator DASCHLE. Thank you very much.

The CHAIRMAN. And thank you all very much.

Senator PACKWOOD. Great panel. Excellent.

The CHAIRMAN. We are so much in your debt. We will continue to turn to you for advice. Again, thank you indeed.

Dr. HELMS. Thank you.

Dr. CUSTER. Thank you.

The CHAIRMAN. Superintendent, particularly for coming all the way from New York.

Mr. CURIALE. My pleasure.

The CHAIRMAN. We will now go to our second panel. It is a very special pleasure that the Committee on Finance welcomes an old friend and colleague from the Committee on Ways and Means, Mr. Willis Gradison, who is the president of the Health Insurance Association of America. Mary Nell Lehnhard, who is the senior president of the Blue Cross and Blue Shield Association. We welcome

you, Mrs. Lehnhard. And William P. Link, who is chairman and chief executive officer of the Prudential Insurance Co. of America.

Mr. LINK. Of the Group Operation Department.

The CHAIRMAN. Of the Group Operation Department. All right, sir.

Mr. Gradison, you are first. And again, you are very welcome, sir. You have been very patient sitting back there all morning. We are a little bit behind because we had a vote at 10:00. Proceed exactly as you like.

STATEMENT OF HON. WILLIS D. GRADISON, JR., PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA, WASHINGTON, DC

Mr. GRADISON. Thank you, Mr. Chairman. I am Bill Gradison, President of the Health Insurance Association of America. I want to thank you for this opportunity to testify today. I will, of course, summarize my written testimony and request that the entire statement be entered into the record.

The CHAIRMAN. Without objection. It will be the case for each witness.

[The prepared statement of Mr. Gradison appears in the appendix.]

Mr. GRADISON. Thank you, Mr. Chairman.

The Health Insurance Association of America, Mr. Chairman, supports comprehensive reform of our health care system to achieve universal coverage for a federally defined benefit package. No one should lose coverage because they get sick, change or lose their job.

As you requested, Mr. Chairman, my testimony today focuses on reform of the health insurance market. HIAA recently had a preliminary meeting at the White House with Ira Magaziner, Harold Ickes, and George Stephanopolous. We shared with them some of our ideas on this same subject. We are happy to have the chance to talk with you about this.

Mr. Chairman, as we discuss health insurance market reform, it is critical to spell out the assumptions on which our recommendations rest.

First, these new rules should apply to a federally defined comprehensive set of benefits.

Second, these reforms apply only to medical reimbursement plans and not to other types of coverage such as disability income protection and Medicare supplement policies.

Third, these reforms should be implemented only under a system of universal coverage. Without universal coverage, Mr. Chairman, the rules I am about to outline might not achieve the intended goals and might, in fact, have unintended adverse effects.

And fourth, these rules should apply to all carriers and to self-insured plans.

With these assumptions in mind, assumptions which we believe are shared by many who are considering alternative approaches to health reform, we recommend the following insurance market reforms.

Coverage must be universal and continuous. There must be no pre-existing condition limits once an individual is in the system.

And the problem of job lock must be eliminated. Coverage must be provided to whole groups. No one in a group could be excluded regardless of health status. Coverage could not be cancelled because of the health status or claims experience of any individual or group. Rating restrictions should prevent large rate differentials among groups of similar demographics.

Mr. Chairman, the HIAA opposes pure community rating because it results in market disruption and works against cost containment in a variety of ways.

A standardized paperless system should be developed through the use of a uniform claims form or electronic data interchange.

And finally, solvency requirements must be established for all carriers and for employers choosing to self-fund. This will help to ensure that benefits are available when needed.

Because individuals and small employers face serious problems in today's marketplace, we recommend two additional reforms for these markets.

First, carriers should be required to guarantee issue. That is, carriers selling in the individual and small group markets would have to issue the defined benefit package to any qualified applicant regardless of health status or prior claims experience.

Second, in a system of universal coverage carriers selling to small employers or individuals should be required to use modified community rating. Rates could vary under our recommendation based on certain objective demographic characteristics. But rates could not vary based upon health status or claims experience.

Two important reforms will sharply reduce the incentive for carriers to seek out good risks and avoid bad risks. First, all carriers in the individual and small employer markets should be required to participate in a risk sharing mechanism. This would eliminate cherry-picking because there would be no advantage from selecting good risks.

Second, marketing rules should prohibit carriers from engaging in risk selection through marketing, service or delivery of care. Marketing must also be based on accurate and uniform cost and quality measures to allow easier, more effective comparisons among health plans.

Mr. Chairman, on a related subject, one of HIAA's actuaries just completed an analysis of the cost of the benefit package included in the Health Security Act. Mr. Chairman, I would ask that a copy of that study be included in the record.

The CHAIRMAN. We would be very happy to do.

[The study appears in the appendix.]

The CHAIRMAN. Do you want to tell us what it is?

Mr. GRADISON. Mr. Chairman, this is the first peer reviewed actuarial study that we are aware of of the cost of the benefit package in the administration's plan. The conclusion of this study is that the administration has underestimated the cost of the package by about one-third.

Our numbers are very close to the numbers that were developed by the Hewitt Study, which was separately completed very recently. So far as we know, the administration has not yet released an actuarial opinion or an actuarial report on their own projection.

I bring this up recognizing its importance and to indicate that we would be happy to have our actuary available in any way you might see fit, whether through testimony or consultation with you and your staff on that important issue.

The CHAIRMAN. We thank you. We accept that offer. I might record that the Congressional Budget Office will be presenting its estimates to us in our hearing next Wednesday.

Mr. GRADISON. Thank you, Mr. Chairman, for the chance to be with you. I look forward to your questions.

The CHAIRMAN. It is a please.

Mrs. Lehnhard?

STATEMENT OF MARY NELL LEHNHARD, SENIOR VICE PRESIDENT, BLUE CROSS AND BLUE SHIELD ASSOCIATION, WASHINGTON, DC

Mrs. LEHNHARD. Mr. Chairman and members of the committee, I am here representing the 69 independent Blue Cross and Blue Shield plans. We very much want to see a bill enacted this year that (1) assures universal coverage through some combination of individual and employer responsibilities; (2) controls costs by creating incentives for consumers to use efficient, high quality organized delivery systems; and (3) reforms the insurance market.

While we support all of this three-part program, we think that the insurance reforms are the foundation of reform that the public wants. We believe that these new accountable health plans should be required to accept everyone, regardless of their health, age or employment status; not drop a group or an individual when they get sick; strictly limit the use of waiting periods for pre-existing conditions and get rid of them entirely when someone has previous coverage; offer a limited number of standardized benefit packages so consumers can compare value easily; use community rating for demographic adjustments for the individual and small group market.

And given the discussion this morning, let me elaborate on that. We think you do need to limit the use of community rating to the individual and small group market, particularly as you start out in reform and the first steps of reform. Leave the large group market experience rated.

Senator PACKWOOD. What is your definition on that?

Mrs. LEHNHARD. Two to 100 for the small group.

Senator CHAFEE. What did you say again? What number, please?

Mrs. LEHNHARD. Two to 100.

We have done a number of studies——

Senator CHAFEE. In other words, community rating for 100 and below?

Mrs. LEHNHARD. And the individual market separately. We have done a number of studies on this and I would be glad to provide you with those studies. Our objective is to minimize disruption and premium shock as we move to community rating. We say take a first step, digest it, and then look at the next step.

We also think you need limited, very limited, demographic adjustments in the beginning—age and geography. And we would not have a separate pool based on geography. We would have a single pool for, say, the whole State of New York, with minor adjustments

allowed based on the cost of upstate New York or downstate New York, not an entirely separate pool.

We also think you need transition flexibility to minimize shock. One other reason I would mention that you want to keep community rating at groups of 100 and below is that we think it is very important that you require everybody to participate in the community rated pool. No self-funding or employers will begin to decide whether their own employees have a better risk or the community rate is a better risk. You will see gaming against the community rate by employers who self-fund, either on their own or through multi-employer welfare funds.

Senator PACKWOOD. But the big companies could self-insure?

Mrs. LEHNHARD. We say let them self-insure in the beginning. Look at what you want to do more comprehensively later. Take a first step that is reasonable.

Going back to our list, we also think that accountable health plans should be required to move very rapidly to paperless claims and uniform data formats; provide consumers information on subscriber satisfaction and the quality of care; and importantly, require accountable health plans to be in all lines of business—individual, small group and large group. And you heard quite a bit of that from the Commissioner from New York this morning.

I cannot emphasize strongly enough the effect that these reforms will have on the market, particularly the rule that you have to open your doors for the first time. Under today's rules it is much easier for health insurance companies to be competitive based on risk selection.

Let me give you one statistic—4 percent of any population will generate 50 percent of the claims loss. And far more energy has gone into avoiding that 4 percent of very high users than learning to manage costs. Once we all have to open our doors, we are all going to have to learn to manage our costs or we will not survive.

We believe these new reforms should be Federal standards administered by the States. We do not think you need a new complicated purchasing cooperative to administer them. But some insurance commissioners will need additional resources.

Finally, these changes, while they are needed drastically, cannot occur overnight. We need time to take our subscribers through a transition and avoid disruption as we move to community rating, new practices and new products. However, many of these changes can occur quickly and we have outlined a general time frame in our testimony.

I would emphasize, however, that flexibility in the transition period is extremely important if we are going to avoid changes that have an unsettling and even harsh consequence for subscribers.

In summary, we are excited about Federal reform that will put an end to competition based unrisk selection and give strong incentives to all of us to learn to manage our risks rather than to exclude them.

The CHAIRMAN. Thank you, Mrs. Lehnhard.

[The prepared statement of Mrs. Lehnhard appears in the appendix.]

The CHAIRMAN. And now to our——

Senator CHAFEE. Mr. Chairman, one question.

The CHAIRMAN. Yes, of course.

Senator CHAFEE. Did Mrs. Lehnhard say that 4 percent of the population gives you 50 percent of the costs?

Mrs. LEHNHARD. This is sort of an actuarial truism. You can look at any population, the people in this room. Four 4 percent of the population, of any population, will generate 50 percent of the claims costs. If you can medically underwrite and exclude that 4 percent, you do not have to do anything else to keep your premiums competitive.

That is going to be the major force for cost containment we believe, that once you have to take everyone if you do not learn to manage your enrollment, you cannot stay in business.

One point about the reforms in New York. There has been an overnight growth in managed care in New York, particularly in the small group market, because of the rule in New York that you have to open your doors and accept all risks.

The fee-for-service carriers are not offering their products. It is primarily managed care. We are changing very rapidly. We were primarily fee-for-service.

The CHAIRMAN. Could I just see if Dr. Helms is in the front? He is here. Were you agreeing with the proposition that of 4 percent, 50 percent?

Dr. HELMS. Right. That we are looking at a very small percentage in the population that is generating the cost.

The CHAIRMAN. Good. And your point is that if you spend your time trying to avoid that 4 percent——

Mrs. LEHNHARD. That is where the investment is going.

The CHAIRMAN. That is where the investment is going. Well, we will get back to that.

Mr. Link?

STATEMENT OF WILLIAM P. LINK, CHAIRMAN AND CHIEF EXECUTIVE OFFICER, GROUP OPERATIONS, THE PRUDENTIAL INSURANCE COMPANY OF AMERICA, NEWARK, NJ, ON BEHALF OF THE ALLIANCE FOR MANAGED COMPETITION

Mr. LINK. Thank you, Mr. Chairman and members of the committee. My name is Bill Link. As Senator Moynihan said, I am the Chairman and Chief Executive Officer of Group Operations for The Prudential. But I am here today on behalf of the Alliance for Managed Competition, the AMC.

This is a coalition of five managed care companies working towards comprehensive health care reform. The members are the AETNA, CIGNA, The Prudential, The Metropolitan, and The Travelers. And collectively, we provide health coverage to more than 60 million Americans.

As Senator Hatch said earlier in his comments, it has been pretty easy for those who propose reform to blame the insurance industry for most or all of the health care problems today. But as easy as it is to say that, and to blame them for standing in the way of reform, I think what you have heard from Bill and from Mary Nell, and what you will hear from me, is that that simply is not so.

We are for fundamental health care reform in this country. The fundamental problem in today's health care system is the incentives. The incentives for providers, the incentives for consumers,

and the incentives for insurers are really stacked wrong. Some of the things you are considering changing today hopefully will restack some of that correctly.

Let me first deal with the idea of insurance companies standing in the way of progress. The companies that make up the AMC do not even refer to themselves as insurance companies anymore. We refer to ourselves as managed care companies. Why? Because managed care is what we are selling and what the marketplace is buying.

As Mary Nell said, there is a strong movement in New York and other places to managed care. Overall enrollments in managed care plans has now increased to 90 million individuals in this country—eight times the level it was just a decade ago.

In this country we have been moving from a business of risk selection to one of risk management. We are managing that risk better and better. The rate of increase in health care costs is coming down. The Bureau of Labor Statistics data shows steadily decreasing rates of health care inflation from a little over 10 percent in 1990 to just a little over 5 percent in 1993.

Quality is improving also. From our own standpoint, I am talking about The Prudential, and this is true of other companies, too, our customer satisfaction surveys which we do quite regularly show that our members are liking the services we are providing.

The industry is working collectively to develop tools like the Health Plan and Employer Data Information Sets called HEDIS. HEDIS will allow us to provide report cards to individuals so they can compare our quality and cost effectiveness.

The market has been working and organizations like ours have long supported reform proposals that would expedite these positive changes. For instance, the AMC supports the development of a standardized benefit plan, as mentioned by Mary Nell and Bill.

We also believe no health plan should discriminate against an individual on the basis of health status or medical history. In other words, coverage should not be at risk if a person changes jobs or has a change in any other life characteristic. And once an individual is in the system he or she should not have to satisfy a pre-existing conditions exclusion. The AMC also supports guaranteed renewability and availability.

However, these reforms alone will not do the job we believe. For instance, we think changes are needed in the demand side also, to incent consumers to make cost effective choices. So we would support changes in the tax treatment of employer provided health care benefits to make consumers more cost conscious and price sensitive.

We cannot rule out pre-existing conditions limitations without recognizing that there has to be responsibility on the part of individuals. People cannot be allowed to wait to buy health insurance until they are sick and then look to the protection of guaranteed issue. There must be rules about access to coverage and perhaps only a certain enrollment time each year.

A critical step in ensuring access for individuals and small employers, and in simultaneously ensuring that plans are not risk selectioning, we believe, is the formation of purchasing cooperatives or alliances. However, the concept of cooperatives was designed to

improve access for those who are having access problems—individuals and small employers.

Some of the reform proposals today would set these alliance sizes at 1,000 or even 5,000 employees. We think the right answer is more like 50 or 100.

These sorts of market-based changes will do the job we believe. Proposals that include price controls will do just the reverse. They will stall the access to the capital that we need to continue to make changes and reduce costs, like electronic systems to eliminate paper claims that Mary Nell mentioned.

We need to look for savings by incenting everyone to manage costs, not eliminating investments in our future. The bottom line is that the AMC companies believe insurance market reforms are a key element in the health care reform debate and will move the market away from that based on risk selection to one based on risk management.

The Prudential and the AMC are committed to achieving health care reform. We look forward to the time when all Americans will be able to make informed choices about their coverage based on quality and cost.

I would be happy to entertain questions.

[The prepared statement of Mr. Link appears in the appendix.]

The CHAIRMAN. Thank you very much, sir. That is a very appealing phrase, to move from risk selection to risk management. I think is very much what Mrs. Lehnhard was saying and I think Mr. Gradison agrees.

I was very much impressed by how much agreement there is in this panel. Not in any way to be disagreeable, but can I ask, Bill, if you are in so much agreement about the basic thrust of reform legislation, do not those advertisements suggest some dissidence in your organization or do you not run the promotion plans? What is the HIAA trying to tell us?

Mr. GRADISON. Mr. Chairman, what we are trying to say is that it is possible, indeed desirable, to achieve universal coverage without having mandatory, monopolistic health alliances. We are also saying that it is really a role of the dice with the health care system to put future health care spending on automatic pilot by having statutory limits, premium limits which have been recommended.

I appreciate that when we make those points they are or have up to now been controversial. But judging by statements that have been made within the last 24 hours from the White House itself, it appears that there are people at the other end of the avenue who are open, let us say, to the possibility that an acceptable plan with universal coverage can be achieved without necessarily having these large mandatory alliances and premium limits.

The CHAIRMAN. Could I ask, could you name one of those people? [Laughter.]

Mr. GRADISON. Well, I just go by papers that are published in your State, Senator.

The CHAIRMAN. All you know is what you read in The New York Times. Well, that is all right.

Do I take it that, Mrs. Lehnhard, Mr. Link, that you would be of that disposition that Mr. Gradison just laid out? I think that is

very clear in your statement on page 7 that "nine managed care companies lost over $7 billion in market capitalization over a 2-week period just in response to reports that price controls were to be imposed." Were you one of them?

Mr. LINK. We are not a publicly traded HMO.

The CHAIRMAN. You are not publicly traded?

Mr. LINK. No.

The CHAIRMAN. But I take it—I am not asking you to agree. I am just saying——

Mrs. LEHNHARD. I think the only point of disagreement might be, that Mr. Gradison and ourselves believe that you do not need mandatory alliance of any size, even where the alliance is a smaller mandatory purchasing cooperative.

We think that when you start to peel apart what the alliance is supposed to do, many of those functions are performed by or accomplished by insurance reform. For example, the alliance itself does not have anything to do with pooling purchasing power.

The pooling of purchasing power is the community rate that the health plan has to offer. That is what makes us give our best rate to the highest cost group. The sickest group gets the same rate as the healthiest group.

The CHAIRMAN. I see.

Mrs. LEHNHARD. You do not need an alliance to do that.

The CHAIRMAN. Mr. Link, would you agree with that?

Mr. LINK. I think Mary Nell is correct. We would favor more an exclusive alliance type concept. I will say this. When the purchasing cooperatives, alliances—the same term were first talked about they were much more benign. They were meant to be like farmer's cooperatives, a market facilitator.

I think what has happened is some of the proposals have put alliances in a much more regulatory bureaucratic framework which has scared a lot of people away from them. It is possible that a voluntary alliance or cooperative could work or a multiple competing alliance arrangement can work. We are not opposed to trying that. In fact, we participate in Florida and in California, both of which have voluntary alliances now.

A concern I do have is one that Senator Packwood mentioned earlier, the risk selection process. If you have a voluntary alliance and you allow companies to operate outside of that alliance and they get two requests, one from Asbestos Are Us and one from some small computer development, software developing firm, I can tell you which company's phone calls they are first going to return.

If they had to do that in an alliance where it was blind as to what happens, you would not have that process. That is a concern. It may not be an overwhelming concern, but it is a concern.

Our main point about the alliances is that, at 1,000 or 5,000 employees they are just way too big, and they should be kept down in the 50 to 100 range.

The CHAIRMAN. Fine.

Mrs. Lehnhard—really I am going to turn; it is Senator Packwood's time now—but you had wanted to say something. Please.

Mrs. LEHNHARD. Just to follow up. The point was made earlier I think by Senator Daschle that you do not want risk selection to occur because you have voluntary purchasing pools. We think the

way to overcome that is to say that the health plan has to offer its community rate, whether it sells through the alliance or it sells directly. Then the alliance does not come in and essentially cherry-pick the market.

Your pooling goes back again to the community rate of the health plan itself.

The CHAIRMAN. Fine.

Senator DASCHLE. But that does not deny adverse selection. You still have the ability to adversely select. Even though you can community rate, you can go out and find your customers.

I am sorry, Mr. Chairman, but I just wanted to note that.

The CHAIRMAN. No. We are all here together now.

Mr. Gradison?

Mr. GRADISON. Mr. Chairman, in order—let us take the President's plan as an example—mandatory requirements that most Americans purchase through the health alliances. The only way that can work is with an effective combination of a risk adjuster and reinsurance, maybe both. Because if only by accident, there are going to be some plans that are offered within the health alliance that will have better experience than others. They may or may not be more efficient.

What we believe very strongly is that as a consideration for offering a health plan to the public, whether it is through the health alliance or not through the health alliance, the same rules should apply, including the application of the risk adjuster and/or the reinsurance mechanism. We believe that that would meet the concern which you quite properly have expressed.

The CHAIRMAN. Good. Thank you very much.

Senator Packwood?

Senator PACKWOOD. Bill, you very carefully said that we can achieve universal coverage without mandated health alliances. The previous panel, however, said we cannot achieve universal coverage without mandates. Forget the health alliance part. Do you agree with the conclusion you have to have mandates to get universal coverage?

Mr. GRADISON. Absolutely, Senator. I see no way without mandates on somebody to do something, it could be business or it could be individuals or it could be the government, and as some single payer systems would do, but otherwise there are going to be some people who for whatever reason choose not to participate.

Senator PACKWOOD. Dr. Helms indicated quite a few people will not participate short of mandates, no matter what kind of incentives you offer.

Mr. GRADISON. I think he is absolutely correct on that. Frankly, one of our greatest concerns from the discussion that has been taking place in the last few weeks is the possibility that universal coverage might be phased in over a very long period of time.

This creates from an insurance company point of view enormous problems, because if we have the insurance reforms up front but the mandate to buy the insurance is years off, there is a risk of people coming in to buy just before they are going in for the surgery, which simply would mean an increase in rates and a discouragement to some people even to buy the insurance.

Senator PACKWOOD. There is a risk. But if you were to perhaps shorten the time for reaching the mandate sufficiently that the President could embrace it and extend the time for the reform sufficiently that you did not have the effect you just indicated, that might be room for compromise.

Mr. GRADISON. Mr. Chairman, we are trying to think this through and do not have the final answers at all. But in principal I would suggest that the concept that insurance reforms would phase in as the universal coverage would phase in and that might be done for different population segments or group size. But that is not the final thought.

We are just saying there is a problem there and we would like to seek it out with you.

Senator PACKWOOD. Do the other two agree, we cannot have universal coverage without mandates?

Mrs. LEHNHARD. We supported some combination of employer and individual mandate.

Senator PACKWOOD. Mr. Link?

Mr. LINK. It may be long term, but that is true. The Alliance for Managed Competition is not in favor of employer mandates. I will tell you from my own standpoint, I believe some of what Senator Durenberger said, the changes made in Minnesota got about half of the people in a very short period of time. I would be much more in favor of starting down that, making these reforms, seeing who got covered.

It is probably true that you will not get 100 percent of the people covered. But then look and see who is not covered, why they are not covered and target the solution to that, rather than start at the beginning with what you think is a preconceived notion and stick an employer mandate in that may not be the best solution in the long run.

Senator PACKWOOD. What about an individual mandate?

Mr. LINK. It may be that Senator Chafee's idea of an individual mandate is the thing that will eventually be needed to cover everyone.

But even in a State where there is an auto insurance mandate, I think in Minnesota there is a mandate for auto insurance, only about 93 percent of the people are covered.

Senator PACKWOOD. Correct me if I am wrong. Germany's mandate is an individual mandate in theory. Most people buy it through their employer and the employer pays half of it, but it is a payroll deduction. And Germany comes close to achieving universal coverage with what they call an individual mandate, unless I am mistaken. Correct me if I am wrong.

Mr. LINK. I cannot correct you.

Mr. GRADISON. There is a significant number of people—the number that comes to my mind is 10 percent, that may be off slightly—that are not covered under the State system in Germany because higher income people are permitted to opt out, a very high percentage of them by private health insurance.

Senator PACKWOOD. But for a very understandable reason they opt out because the German payroll deduction is a percentage of wages and there is no cap. And you get up to $200,000 or $300,000 a year with what you pay in a payroll deduction, you can opt out

and buy private insurance for a better price than you would pay on your payroll deduction.

So that is not so much a question of—I would not worry about that. If people want to opt out and buy individual insurance because it is too high in the pool, you are going to have to be pretty high income before you think about opting out.

Mr. LINK. Senator, you asked a question a little earlier in response to a statement where I think David said—or maybe it was Bill Custer—you would have to have an individual mandate even with an employer mandate. You said that is because some people do not work. Well, that is part of it.

Unless you are going to have the employer pay 100 percent of the premium, the employee is going to have to pay some percentage of the premium. And some of those employees will choose not to pay that percentage of the premium. So you will not get——

Senator PACKWOOD. Unless they have to.

Mr. LINK. That is what I said. So you have to have an individual mandate along with an employer mandate if your goal is to get everybody covered.

Senator PACKWOOD. Now let me shift a moment to community rating because Superintendent Curiale kind of said, I tell you, it is not worth the trouble. By the time you try to figure out who smokes and who does not, and who exercises and who does not, and who drinks and who does not, it is not worth the trouble.

But I sense all of you do not agree with that. You would have a reasonable variance in community rating for demographic or age or sex. I am not quite sure of what conditions. Do I read it right?

Mrs. LEHNHARD. But I do not think any of us are saying you allow variations for health status.

Senator PACKWOOD. No, no. I understand that. But would you allow it for style of life? Bill, you would not.

Mr. GRADISON. No, Mr. Chairman, I think it should, if there are to be variations they should be objective, demographic factors. We have, I have to acknowledge, thought also of age.

Senator PACKWOOD. Age is a demographic.

Mr. GRADISON. And the geographic factor is very important because health care costs very enormously——

Senator ROCKEFELLER. Mr. Gradison, you are not telling the truth, sir. You have it right in your testimony that you say "should be allowed to establish premium rates that provide incentives for healthy life styles and managing care."

Mr. GRADISON. May I explain? I was about to explain that, Senator.

We think it reasonable in addition to the objective demographic factors that have already been mentioned to consider a catchall that might be permitted in the way of a discount, 10 or 15 percent comes to mind. These things I think are objective. Did your children get the vaccinations when required? Have you had your annual cholesterol check? Do you smoke? A combination of those I think would encourage wellness and would not get into what I would call life style factors.

Let me be very explicit. This is not in any way intended to get into such things as sexual orientation or anything of that kind. We are trying to encourage objective treatment.

Senator PACKWOOD. I was not thinking about that when I asked the question. I understand the sensitivity. I was thinking more of the drinking, and the physical exercise, and the smoking. I did not mean to tread on sensitive ground.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. Do you not remember that whenever people jog they sprain their ankles? [Laughter.]

Senator PACKWOOD. It is an unhealthy life style.

The CHAIRMAN. Do you know the risk of moving an individual unprotected through moving vehicular traffic?

Senator PACKWOOD. I am reminded of our former colleague, Bill Hathaway, one time. He was a great golfer, but did not really care for much of anything else. But he took up some other exercise at some rigor for 2 or 3 months and I asked him how he was doing and he said he had given it up thank God and he felt a lot better since he gave it up. [Laughter.]

The CHAIRMAN. Senator Rockefeller, you are next.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

I suspect nobody will be surprised if I concentrate my questions on you, Mr. Gradison. I will start by saying that I think that the advertising that you have instructed and that your HIAA has been putting on television throughout this country at the cost of $8 to $10 to $15—God knows where it will end up—millions of dollars is probably the single most destructive effort that I can remember in 30 years of public life at trying to undermine public policy that this country desperately and definitely wants.

You hold up your paper here and you talk about all the things you would like to see, knowing full well that the American people, of course, will never see this, nor will they ever hear it. What they see is what you pay for, which is that Harry and Louise know that there is a better way. You talk about giant bureaucracies and you are scaring people.

You are scaring people in general about the whole concept of health care reform, not just the Clinton health care reform, but any kind of health care reform that has substance that might include community rating or other things that you do not want.

My question—I guess it really is not a question. My statement to you is that I think the reason that you are against a lot of these things is that right now you have the consumers right where you want them. Blue Cross and Blue Shield happened to go broke in West Virginia and left a lot of people very unhappy. They did not have a very good experience in West Virginia.

But the groups that you represent, Mr. Gradison, many of them have very high overhead, administrative costs, because they are small and because it takes them quite a lot of money to pay somebody to investigate medical histories. Blue Cross and Blue Shield of Washington, in fact, denied my oldest son and oldest daughter coverage. I assume it was not because they were not able to afford it or their parents were not.

They sent detectives out to find out something. They said my son had a slipped disk. Well, it was not him. That was me. That was 30 years ago and I am fine. They talked about my daughter's cholesterol count. She could not get health insurance because of it. She

is up at 5:30 every morning and exercising and her cholesterol count is probably around 120.

In any event, I think your businesses are unhappy because you now have the consumer right where you want them and you have power over the consumer. And you go ahead with a business and you negotiate more or less on your terms what you want and then you and the business hand that to the consumer and the consumer says, well, this is what I got and this is what I have to pay, and up go the insurance premiums, 15, 20, 25, 35 percent each year whether it is for a person or for a small business; and your people are doing just fine.

The people that are really getting shafted are the American people. You talk about bureaucracies. You have written the book on bureaucracies. The insurance industry has written the book on bureaucracies. You are the people that have the big tall buildings. Maybe not you, maybe some of these others have the big tall buildings—8 to 10 stories with marble and statues all over the place, and paintings by Sevrat.

I mean, you are the people that do the bureaucracy. What we are trying to do in this, and whether this is the Clinton plan or the Breaux plan or the Chafee plan or whatever plan it is, we are trying to get rid of bureaucracies through alliances and that threatens you. Because that threatens to take the power away from you and give it to the consumers who are aggregated in large numbers into alliances so they can more effectively negotiate with you and with the providers.

That is a real power loss for you. And I think that is a real, frankly, job loss for some of your membership, which is, I think, the fundamental reason you are spending $10–$15 million on the air to scare the American people on health care in general, not just about insurance reform. You do not particularly talk about that.

You talk about bureaucracies. You hit all the standard buttons that get Americans nervous. You are having an effect. You are very skillful as an executive. You are having a very good effect. You can see the distrust of the Clinton plan coming down as your ads, which are the only ones out there because we do not have the money to go ahead and try and counteract them.

But I would say you are the person that gets upset by reform because then all of a sudden the consumer has the power. And then they have power over you. They tell you that you have to come to them if you are still in business, that you have to come to them and they are not interested in 20 or 30 percent administrative costs.

They want insurance on the terms that they ought to have it and at which they can afford to have it. That is the only basis in which we ought to be doing business around here. You can comment as you wish.

Mr. GRADISON. Thank you, Senator. During the transition period prior to the new administration coming into office in late 1992, we made public our vision for health reform in America which I outlined earlier—universal coverage, a federally defined benefit package, an end to exclusions on the basis of pre-existing conditions, a universal single claims form, and even the controversial employer

mandate. We were probably the first business group in America to endorse the employer mandate.

During that period the transition team for the Clinton health plan—I think it was actually Judy Feder who worked with us together when we were involved in the work of the Pepper Commission—described our views as "progressive." I think they still are.

Senator ROCKEFELLER. Are any of those in your ads?

Mr. GRADISON. The answer is yes, sir. They are. Yes, they are.

The CHAIRMAN. May I say, Senator Rockefeller, I hope you will take as much time as you feel is appropriate.

Senator ROCKEFELLER. I have said, Mr. Chairman, what I want to say.

The CHAIRMAN. We will give Mr. Gradison as much time as he needs.

Mr. GRADISON. I would just like to go further if I may very briefly.

The rules that apply to insurance regulation up until now, health insurance regulation, have been following a traditional insurance model which applies in other fields of insurance—life insurance, property insurance, and so forth—when there is a direct relationship between the risk and the premium, and where the companies issuing the policies are not required to issue them.

If my teenage son has too many accidents, I am going to not only pay more for auto insurance—I might have trouble getting it except in certain States. We are agreed that that paradigm no longer should apply to health insurance.

What we are talking about is moving away from the traditional method of regulating health insurance in this country to a social insurance model where everybody is going to be covered. Now there will be differences of opinion exactly on how to share those costs and how to phase it in. But those are minor compared with the agreement that we want to change this entirely. Not only change it, but move toward a system in which the regulation has been 50 different ways, and move to one where is based on the major key points a degree of uniformity.

You refer to our membership. I would like to comment about our membership. We cover the entire gambit, from pure old-fashioned plain vanilla indemnity plans to essentially pure plain vanilla HMO's. Our membership on the HMO side includes some companies which so far as I know do nothing but HMO's, like FHP or Humana. It includes companies like New York Life, which are both indemnity and in a growing and major way in HMO's, HealthPlus down here.

We are trying to offer our best recommendations to those of you who have the responsibility for creating public policy. We have expressed the concerns which you are alluding to and we are convinced that there will be a better plan if it does not mandate these health alliances and if it does not have premium limits. That is our advice.

The CHAIRMAN. Senator Rockefeller?

Senator ROCKEFELLER. Mr. Chairman, I think that is extremely disingenuous. It is easy for Bill Gradison to say that. He knows perfectly well, or if he cares to differ, I am perfectly happy to have him say so, that the advertising campaign that he has put on is

basically is the most extensive advertising campaign I can ever remember. I remember living through the Panama Canal. I do not remember anything even close to what Bill Gradison's HIAA has been putting on to scare the American people.

You are basically scaring the American people away from health care reform. It is this Senator's judgment that you are doing that. You can talk to yourself about having all of this or that goals in mind, but what you are doing is scaring people.

When you scare Americans you can do it very successfully and you can do it very easily by pushing certain hot buttons. You have found them all and you are using them all very effectively. I find it very, very sad.

The CHAIRMAN. Can I say, if you will allow me, that I am going to associate myself with Senator Rockefeller on this. I do not watch a lot of television and it was not until I was on the Evans and Novak program on Saturday that they put on and they had me watch Harry and Louise. It would not come under the heading of a public service. [Laughter.]

There was no information. There was only portent. What is going on? They are doing something to us. No one is doing anything to anyone around here. We are trying to do the sort of things you did when you were a member of the Congress.

You are after all using premium money to do this, which is your right.

Senator PACKWOOD. Let me just put in my two bits worth. Frankly, Bill, I do not find your ads nearly as scurrilous, if that is the word people want to call them. Many of the political ads that I have seen that members of this Senate run against their opponent, let alone what their opponents run against them.

As far as I am concerned, if your ads have the effect of convincing the people we should not have these mandatory health alliances, you have done a public service.

The CHAIRMAN. The Chair is going to have to make a ruling here. [Laughter.]

If the quality of political campaign ads is what we are going to measure against, it will undoubtedly be the end of civilization as we know it. [Laughter.]

No. No. Do you want to reconsider that? [Laughter.]

Senator Rockefeller?

Senator ROCKEFELLER. Nothing further, sir.

The CHAIRMAN. Senator Daschle will be our last questioner once again.

Senator DASCHLE. Mr. Chairman, I also have to associate myself with the remarks of the Chairman and the Senator from West Virginia.

I have known Bill Gradison for a long time as Congressman Bill Gradison. The one word that I have always associated with Congressman Bill Gradison was integrity. We would differ on issues as a member of the Ways and Means Committee. But I always felt that Bill Gradison had integrity. These ads do not have integrity. These ads do not reach the standard of integrity that Bill Gradison was associated with for many, many years as a member of Congress.

I differ strongly with Senator Packwood. I do not think the pursuit of truth can be justified by the utilization of half truths. That is what this is—half truths.

I, as Senator Moynihan has indicated, am very concerned that rather than using premium dollars on insurance products, we are using them to spoil the debate that is so critical if we are going to arrive at the right decisions.

I hope that at some point HIAA will reconsider its methods of involving itself in this very serious debate.

The presentations made this morning were excellent. I differ with many of the points raised. But they are legitimate differences. Your rational for taking those different positions are not based on half truths, but on the assumptions about what is best for your industry. There is nothing to apologize for that.

But I must tell you, I am very, very concerned about taking a political approach, one we see all too often. It is no secret that the perception of Congress today is the worst it has been in 100 years. We are down at around 19 percent favorability. Why? Because the public see those awful ads Senator Packwood has talked about.

I do not want to do to health what we have already done to Congress. I hope that somehow, someway we can enlighten the American people, engage them and not frighten them; 78 percent of the American people, according to a poll I just saw this morning, believe there is a health insurance crisis. What do you believe?

Mr. GRADISON. May I start?

Senator DASCHLE. Yes.

Mr. GRADISON. I believe that there is a health insurance crisis for those who have no insurance or have fears, very legitimate fears, of losing their health insurance. I think that there are many Americans, perhaps the majority, who might not use the word "crisis" to describe their own situation. I think it is both.

I think there is a definite need to change the way insurance is regulated in this country to provide universal coverage. I have been——

I would like to respond—if I were still here it would be a point of personal privilege. But basically I am still the same person, Senator. I am a dove turned hawk. The way in which this debate got started last year, not in the Congress, but elsewhere, was premised in part upon the notion that health insurance could be sold by blaming the current problems on the health insurers. I could document that at great depth in writing if it were necessary to do so.

What I would hope we could do—and I have said this to the White House, and while they can speak for themselves I think there is an agreement—is to not get into who cast the first stone, but get into working together to find answers for the future. That is certainly my hope.

As for our media program, it is always subject to review and revision.

Senator DASCHLE. Well, I certainly hope so.

Mr. GRADISON. Thank you, Senator.

The CHAIRMAN. Mrs. Lehnhard?

Senator DASCHLE. Could you respond to the question about whether or not we have an insurance crisis?

Mrs. LEHNHARD. I would respond in the same way. Without question, for those individuals who have been dropped, who cannot get it an affordable price, who do not have an employer contributing, it is very much a crisis for them personally and their family.

I think that all of this panel has laid out that we need universal coverage, insurance reform, and a strong cost containment strategy.

The CHAIRMAN. Fine.

And, Mr. Link, it evolves to you to have the last word.

Mr. LINK. In the interest of time, I agree exactly with Mrs. Lehnhard.

The CHAIRMAN. You mean all we have to do is run long enough and you agree?

Mr. LINK. No. I do agree with her.

The CHAIRMAN. It was a fine hearing. Thank you, Senator Packwood. Thank you, Senator Daschle. Thank you, Mr. Gradison, Mrs. Lehnhard, Mr. Link. We thank our audience and we thank C-SPAN.

[Whereupon, at 1:00 p.m., the hearing was adjourned.]

APPENDIX

Additional Material Submitted

Prepared Statement of Salvatore R. Curiale

INDIVIDUAL AND SMALL GROUP HEALTH INSURANCE REFORM IN NEW YORK STATE

Mr. Chairman and Committee Members, I am Salvatore R. Curiale, Superintendent of Insurance for the State of New York. Thank you for your invitation to testify today concerning New York's efforts to reform the individual and small group health insurance markets in the State.

Open Enrollment and Community Rating for Individuals and Small Groups

In July of 1992 open enrollment and community rating legislation was enacted in New York.

The major provisions of that legislation included the following:

—Any health insurer offering an individual or small group contract in New York was required to accept all applicants.
—All individual and small group health insurance contracts were required to be community rated, that is, all persons with that contract pay the same rate without regard to age, sex, health status or occupation.
—All HMOs in the state were required to offer individual contracts.
—Persons with health insurance coverage who change jobs must be credited with the time covered under their prior contract when calculating the pre-existing condition limitation.
—A risk adjustment mechanism among insurers was authorized to assure market stabilization.

Issues Leading to Legislative Reform

What prompted New York to embark on a major and controversial effort to change the health insurance financing system in New York as it existed in the early 1990s?

In the 1960s and 1970s most small groups and individuals were able to obtain health insurance coverage through regional Blue Cross/Blue Shield plans or commercial carriers. Health care expenditures grew rather modestly over this time and premiums remained relatively affordable for all participants. In the 1980s, health care costs skyrocketed and commercial health insurance companies began to screen applicants more closely in an effort to avoid the worst risks. At the same time, the largest Blue Cross/Blue Shield plan in New York was expanding its open enrollment policy, making available major medical coverage without underwriting.

Dramatic annual increases in hospital and medical costs during this time were convincing many small employers to seek out lower-cost alternatives. Employee groups that contained the better risks, i.e., the healthier individuals, were able to achieve savings through the commercial health insurance companies which could pick and choose the healthiest and youngest groups.

New York is one state in which Blue Cross/Blue Shield plans have retained their traditional role as health insurers of last resort, thus it was these non-profit insurers that were badly hurt when their best risks began to sign on with lower-price competitors who carefully selected only lower risk customers. Since Blue Cross/Blue Shield plans rely on the experience of their entire community of risks in determining rates for individuals and small groups their premiums began to accelerate as their pools of risks deteriorated. Companies that practiced both community rating (i.e., accepting all applicants without regard to medical condition usually with a waiting period for claims that result from pre-existing conditions) and open enroll-

ment were trapped in a spiral of ever-escalating premiums. As premiums rose, more and more healthy customers abandoned the fold, which meant further rate hikes.

In our review of commercial carrier underwriting rules we found that these carriers generally had a very long list of blacklisted or restricted industries and occupations, that is, small businesses that are absolutely rejected by the insurer. They included such businesses as farms, wrecking and demolition work, restaurants, policemen and firemen, florists and liquor stores, orchestras, actors and other entertainment groups, barber shops and beauty shops, hotels/motels and transportation industries such as taxicabs and trucking and many more.

The list of restricted industries and occupations by commercial insurers grew, leaving Blue Cross as the only option for many small groups. The poorer risks and those without leverage in the marketplace were able to obtain coverage only through the Blue Cross/Blue Shield plans and were required to pay higher and higher premium rates.

As we saw a rise in the number of uninsured persons in the state; as the complaints increased by individuals and small businesses that they were being priced out of health insurance coverage; as we saw the community rated pools of Blue Cross/Blue Shield being significantly reduced in number and becoming more costly; and as we saw more individuals and members of small groups rejected for coverage by some insurers, it became obvious that there was a need to change the existing system.

We believed that the problems we were faced with in the individual and small group market appeared to be caused primarily by allowing the underwriting of health insurance risks and by the existing statutory authority which allowed community rating and experience rating to exist as competing rating methodologies.

We felt the fundamental change necessary in our approach to health insurance protection for individuals and small groups was that less effort should be expended keeping people out of the system through underwriting and rating barriers and more effort expended in bringing people into the system and doing a better job of managing their care and protecting them from the instability that results from widely fluctuating premium rate increases.

This fundamental change in approach to health insurance protection for individuals and small groups could best be achieved through a change in the insurance system which required that these risks be community rated on an open enrollment basis subject to rate approval by the Insurance Department.

Impact of Reforms

In analyzing and evaluating the enactment of the community rating/open enrollment law in New York, its implementation and the resulting changes in the marketplace, we have the following observations and comments:

—The availability of health insurance coverage from all types of insurers (commercials, HMOs and non-profits) eliminated the Blue Cross Plans as the insurer of last resort in New York. Anyone, regardless of health status or occupation, can now obtain health insurance coverage at a community rate.

—It had been predicted that open enrollment and community rating would cause commercial insurers to leave the health insurance market. That fear was unfounded. A few commercial insurers left the individual and small group market, however, they were insignificant writers. All of the major small group health insurance writers remained in the small group market.

—Community rating did cause premium rates to increase for younger insureds, however, about 60% of the persons affected by the change in rates received rate decreases or increases no greater than 20%, including trend. Some carriers combined normal rate increases with the change to community rating and used community rating as the scapegoat for consumer complaints about increases.

—The requirement to provide coverage on an open enrollment basis and community rating of individual and small group health insurance policies accelerated the change by insurers to managed care products.

—Consumers were particularly pleased with the "portability provisions" in the law which allowed them to change jobs without the imposition of a new preexisting condition limitation.

—Empire Blue Cross and Blue Shield, which was in the midst of well-publicized management problems, lost considerable market share just prior to and subsequent to passage of the community rating/open enrollment legislation.

—There was a considerable number of telephone inquiries (900+ phone calls in one week in mid-March, 1993) just prior to and immediately subsequent to implementation of the legislation. In hindsight, staggered implementation of the community rating requirement, such as at time of renewal, would have made the systemic change smoother.

—The initial community rates filed by some commercial insurers with the Insurance Department for use on April 1, 1993, were reduced shortly after April, 1993, because of the competitive small group market. In combination with regulatory pressure to reduce rates for April 1 approval, a strong market dynamic quickly developed.
—The implementation of the law, including promulgation of regulations and necessary regulatory determinations based on interpretation of the law, was even more difficult and confrontational than enactment of the legislation.
—The community rating/open enrollment legislation did not require that all insurers participate in all markets. Only HMOs are required by law to be in the individual market, although they have few individual insureds, and as a result, Blue Cross plans dominate the individual market and commercial insurers continue to avoid the individual business.
—The implementation of a risk adjustment mechanism through establishment of demographic and specified medical conditions pools presents an ongoing challenge which requires continuous oversight and data collection with pools operational in seven geographic regions of the state.
—More needs to be done to reform the health insurance system in New York, including standard benefit legislation, "all markets" legislation and implementation of standard claim form legislation. Standard benefits and "all markets" legislation will be proposed this year and implementation of standard claim forms legislation will also take place this year.

In general, the community rating/open enrollment legislation has made individual and small group health insurance more available to people in New York and it appears that premium rates are more stable. In the small group health insurance market the law seems to be working well as small groups now have greater choice of insurance plans and insurers must compete on the bases of competitive price and management of care rather than on risk selection and different rating methodologies. The individual market continues to present the problem of affordability for many but this situation should be helped in part by the risk adjustment mechanism and by an "all markets" bill which would require that insurers operating in the group market subsidize the individual market.

There has been particular interest in the New York experience with regard to the scope of the reform, our decision to require pure community rating, our establishment of rating areas and our development of a risk adjustment mechanism.

Why "Pure" Community Rating

At the time of enactment of the open enrollment/community rating legislation in New York all Blue Cross/Blue Shield plans in the state were community rating their individual and small group business. In addition, all HMOs were required to community rate all of their business. A change to something less than pure community rating would have been a step backward. So-called modified community rating appears to be a recent development and is really not community rating, which had traditionally meant that age and sex would be eliminated as rating factors.

The selection of groups of 50 or less persons to be affected by the legislation was based on a number of considerations including:

—many insurers considered groups of 50 or fewer persons as small groups,
—those groups most in need of assistance in obtaining and maintaining health insurance coverage were the smaller groups.
—being too ambitious may have caused more political opposition, and
—if it was desirable to expand the groups affected by the law that could be done at a later time.

The New York Law and regulations make a distinction between permissible geographic rating areas for insurers and pooling areas under the risk adjustment mechanism. Individual insurers must charge the same rate to all policyholders having the same contract without regard to age, sex, health status or occupation, however, different premium rates are permitted for different geographic regions not smaller than a single county, provided the regions do not appear to contain configurations designed to avoid or segregate particular areas within a county. Individual insurers thus determine their own geographic regions for the purpose of rating within these constraints.

Risk Adjustment Mechanism

For the purpose of risk adjustment pooling there are seven broad geographic regions established by the Insurance Department generally following the geographic rating areas used by the various Blue Cross/Blue Shield plans in the state.

The risk adjustment mechanism in New York established risk sharing pools for three reasons:

(1) To promote competition among insurers and HMOs on the bases of administrative efficiency and managed care effectiveness.
(2) To deter competition among insurers and HMOs on the basis of avoiding or terminating coverage of people whose health care costs are high.
(3) To encourage insurers and HMOs to enter, remain in, and compete vigorously in the small group and individual health insurance markets, by shielding them from the adverse financial consequences of insuring a disproportionate share of people whose health care costs are high.

Insurance Department Regulation 146 seeks to achieve these purposes by establishing two types of pooling:

(1) A portion of the cost of specified high-cost medical conditions (transplants, low-birth-weight babies, AIDS and conditions leading to ventilator dependency) is pooled among all insurers and HMOs. Through this type of pooling, all insurers and HMOs proportionately share a part of the cost of treating these conditions.
(2) The degree of health risk in each insurer's and each HMO's individual and small group business, as measured by the proportion of its business in broad age/sex (i.e., demographic) categories, is compared to the average degree of health risk for all insurers and HMOs. Insurers and HMOs which have a lower than average degree of health risk in their individual and small group business pay into the pool. Insurers and HMOs which have a higher than average degree of health risk in their individual and small group business collect from the pool. This type of pooling prevents insurers and HMOs from profiting by intentionally or unintentionally "skimming" the best risks; it also protects insurers and HMOs which don't "skim" by compensating them if they cover a disproportionate share of high risk people because of "skimming" by other insurers.

Regulation 146 established seven geographical regions in each of which there are three risk adjustment pools, as follows:

(1) A demographic pool for Medicare supplement business;
(2) A demographic pool for all of the non-Medicare supplement individual and small group (groups of 50 employees or less) medical expense policies subject to pooling; and
(3) A specified medical conditions (SMC) pool for non-Medicare supplement business.

Each demographic pool for a region uses demographics by age, sex and family status to generate an index called the Average Demographic Factor (ADF) for each carrier in that region. A Regional Demographic Factor (RDF) is calculated by taking the average of the ADFs for all carriers in that region. The regional demographic factor represents the average age/sex/family status for that region. Specifically, to focus on the age parameter, each carrier with a younger risk pool will pay and each carrier with an older risk pool will collect. The rationale for the age adjustment in the demographic pools is the recognition that morbidity increases by age and the risk selection that is present by age in a carrier's risk pool can be risk adjusted to eliminate, or at least significantly dampen, the variation among carriers by age.
Each SMC pool for a region collects a premium between $1.25 and $5.00 per individual and between $2.50 and $10.00 per family per quarter from each participating carrier. These premium variations reflect richness of benefits. The premiums fund the reimbursement of a fixed amount to each carrier which experiences a claim for any of four conditions: transplants, neonates, AIDS and ventilator dependents. The rationale for the SMC pool is to reimburse for aberrational catastrophic claims.
Both the demographic and SMC pools have both prospective and retrospective aspects to them. For example, carriers with younger demographic pools can load their premium rates to reflect anticipated pool contributions. The retrospective aspect of the demographic pools takes the form of an annual reconciliation (in May of each year) that "trues up" the expected demographics and claims to the actual experience.
The SMC pools also collect a premium from every carrier and then reimburse for the specified conditions: transplants, neonates, AIDS and ventilator dependents. Retrospective risk adjustment predominates for the SMC pools.
The SMC pools reimburse a fixed amount which has been set low enough to encourage managed care practices. If some carrier incurs less expense than the stipulated amount, then the actual expenses are substituted for the stipulated amount. Because the amounts are set much lower than required to reimburse the full ex-

pense for the condition, the pool has a managed care thrust, an incentive for the carrier to keep expenses or manage expenses down to the stipulated amount.

System development to implement the risk adjustment system was probably required by all carriers in order to extract the appropriate demographic data and, in some cases, perform the demographic calculations. In addition, the administrator of the pools (Alicare) had to develop some systems for administration and reporting, but was able to adapt some existing systems with relative ease.

With respect to the SMC pools, the data collection and submission at this point are minimal so that it is difficult to ascertain the necessary system development work. However, since the New York risk adjustment mechanism is relatively simple, it is not expected to be a major expense item in the larger scheme of things.

Administratively, the demographic pools are collecting money from and disbursing money to the various participating carriers. The calculations necessary for the demographic pools are done on worksheets designed and distributed by the New York State Insurance Department with the cooperation and assistance of its administrator, Alicare. Three quarterly collections and two disbursements have been made with a very limited number of problems.

The SMC pools have collected money, but distributed none to-date. For the most part, participating carriers have not as yet requested reimbursement. The delay in those request is partially due to the newness of the pool and of the rules and procedures for obtaining reimbursement.

Legally there have been several challenges to the pools by the New York HMO Conference and commercial insurers. For those HMOs participating in the lawsuit, payments into the pool have been put into an escrow account until a final determination is made by the courts. Therefore, disbursements have been reduced by the escrowed amounts. Again, pool payments are often a function of a younger risk pool, which is the result of past risk selection practices (including benefit design practices) that encouraged enrollment of younger risks and/or discouraged older risks.

CONCLUSION

We believe that the open enrollment and community rating legislation has rewarded New York residents with a number of significant benefits. As a result of the open enrollment mandate, New Yorkers can obtain comprehensive health insurance coverage from a number of insurers and HMOs without regard to their medical condition their age or their occupation. Community rating has stabilized premium rates and rate increases. While premiums remain high, insureds need not worry that one or two catastrophic claims will result in large rate increases. Further, restrictions on pre-existing condition limitations have afforded portability of coverage allowing New Yorkers the ability to change jobs or individual insurers or HMOs without being subject to new waiting periods for continuing medical problems.

We strongly endorse open enrollment and community rating, including an appropriate risk adjustment mechanism, which have had such a positive impact on the New York health insurance system. We also recognize, however, that additional changes are necessary to further address existing problems with the system. We look forward to working with State and Federal legislators and all interested parties to afford all of our citizens the opportunity to obtain and maintain comprehensive health insurance coverage at an affordable cost.

PREPARED STATEMENT OF WILLIAM S. CUSTER

AMERICANS WITH AND WITHOUT HEALTH INSURANCE: IMPLICATIONS FOR REFORM

Mr. Chairman, I am pleased to submit this statement for the record on health insurance reform. The Employee Benefit Research Institute (EBRI), a nonprofit, nonpartisan public policy research organization, is dedicated to providing objective analysis of health care and other work force issues.

While the employment-based system for financing health insurance coverage continues to provide coverage for 63 percent of Americans under age 65, that source of coverage is eroding for many, especially those who are employed by smaller employers. Eighty-three percent of nonelderly Americans and 99 percent of elderly Americans (aged 65 and over) were covered by either public or private health insurance in 1992 (table 1). Although some of the nonelderly had public health insurance (15 percent), the most common source of coverage was private insurance usually obtained through an employment-based plan.

The number of nonelderly Americans without health insurance increased to 38.5 million in 1992 (17.4 percent of the nonelderly population), from 36.3 million in 1991 (16.6 percent) 35.7 million in 1990 (16.5 percent), and 34.4 million in 1989 (16.1 per-

cent). A primary reason for the increase in the number of uninsured was a decline in employment-based coverage, particularly among individuals (and their families) working in small firms. The number of nonelderly Americans with employment-based coverage in 1992 was 138.0 million (62.5 percent of the nonelderly population), a decrease from 139.8 million (64.1 percent of the total nonelderly population) in 1991 (table 1).

These estimates and most of those presented below are derived from the March 1993 supplement to the Census Bureau's Current Population Survey (CPS). Most researchers familiar with this survey agree that the numbers presented provide a snapshot of insurance coverage at a given point in time during 1992. Another Census survey, the Survey of Income and Program Participation (SIPP), follows a smaller group of individuals over a two-and-one half-year period. The latest available information from SIPP indicates that, in 1987, 32 million (13 percent) Americans were uninsured at any given moment, 50 million (21 percent) were uninsured for some portion of 1987, and 16 million (7percent) were uninsured for all of 1987. Adjusting those numbers for population growth and increases in the number of uninsured to make them comparable to the 1992 estimates from the Current Population Survey yields estimates of 24 million Americans uninsured for the entire year, 38 million uninsured at any given moment during the year, and 58 million uninsured for some part of 1992.

Employment-Based Coverage

The most important source of health insurance coverage is employment-based coverage. In 1992, 62.5 percent of the nonelderly were covered by employment-based insurance (table 1). This is a reduction from 1988, when 66.8 percent of the nonelderly were covered through an employment-based insurance plan.

Declines in employment-based health insurance coverage were somewhat offset by an increase in the number of Americans with coverage from a public source. The number of nonelderly Americans receiving public coverage steadily increased between 1989 and 1992-33.4 million nonelderly Americans received public coverage in 1992 (15.1 percent of the total nonelderly population), compared with 31.7 million, or 14.5 percent, of the nonelderly population in 1991 29.2 million, or 13.5 percent, in 1990; and 26.2 million, or 12.3 percent, in 1989 (table 1). The increase in public coverage is, at least in part, due to the impact of the recent recession and to changes in Medicaid coverage for children and pregnant women.

Workers

Not surprisingly, workers were much more likely to be covered by employment-based health plans than nonworkers. Seventy percent of workers were covered by an employment-based plan, compared with only 37 percent of nonworkers. In addition, 77 percent of individuals in families headed by a full-year, full-time worker were covered by group health plans, compared with only 37 percent of those in families headed by other workers and 16 percent of individuals in families headed by a nonworker.

Workers were also more likely to be covered by an employment-based health plan if they worked for an employer with a larger number of employees. Insurers may charge less per capita for large employer plans because they are able to spread both risk and administrative costs over a greater number of people. Only 23 percent of selfemployed workers and 22 percent of workers in firms with fewer than 10 employees were covered through a group health plan sponsored by their own employer in 1992, compared with 70 percent of workers in firms with 1,000 or more employees.

Workers' family members were also more likely to be covered by an employment-based plan if the family head worked for a large firm. Among workers (and their families) in firms with fewer than 10 employees, 38.8 percent were covered by an employment-based plan, compared with 81.4 percent of workers (and their family members) in firms with 1 or more employees (table 2).

Income and Health Insurance Coverage

Income is also related to health insurance coverage. In general, individuals with higher levels of income are more likely to be covered by private health insurance, while those with lower levels of income are more likely to be covered by a publicly sponsored plan. In 1992, only 16 percent of individuals in families with income below $5,000 were covered by private health insurance, compared with 92 percent of those in families with income of $50,000 or more. Although many individuals in poor families are covered by public health plans, that coverage is far from universal. In 1992, less than 50 percent of the nonelderly with income below the poverty line were covered by Medicaid.

Characteristics of the Uninsured

In 1992, 17.4 percent of the nonelderly population—or 38.5 million people—were not covered by private health insurance and did not receive publicly financed health assistance, up from 36.3 million (16.6 percent) in 1991. Among the 38.5 million nonelderly Americans who did not have health insurance coverage in 1992, most were working adults (56.7 percent), while the remainder were children (25.4 percent) and nonworking adults (17.8 percent). The total number of uninsured under age 65 has increased from 33.6 million in 1988 to 38.5 million in 1992. Although some of this increase can be attributed to population growth, the percentage reporting no health insurance coverage has also increased from 15.9 percent to 17.4 percent.

The uninsured live in families that are generally low income and employed by small employers. Just over 60 percent of the uninsured live in families with total family income of less than 200 percent of the federal poverty level. Fifty-one percent of the uninsured live in families whose family head works for an employer with fewer than 100 employees.

Furthermore, increases in the number of individuals without health insurance were greatest among those whose family head worked for a small firm rather than for a large firm. Among the additional 4.2 million nonelderly Americans without health insurance coverage between 1989 and 1992, 1 percent were in families in which the family head worked for a firm with fewer than 25 employees; 21 percent were in families in which the family head worked for a firm with 25-99 employees; 25 percent were from families headed by a nonworker; 14 percent were from families in which the family head worked for a firm with 100-499 employees; and 21 percent were from families in which the family head worked for a firm with 500 or more employees. The increase in noncoverage among those in small firms was even more pronounced between 1991 and 1992. Forty-two percent of the additional 23 million individuals without coverage between 1991 and 1992 were in families in which the family head worked for an employer with fewer than 25 employees. An additional 15 percent were in families in which the family head worked for an employer with between 25 and 99 employees.

The uninsured also tend to be young. About 25 percent of the uninsured are children under the age of 18. Even among adults, the uninsured tend to be younger than those with coverage. Twenty-seven percent of those aged 18 to 29 are without health insurance, and that group comprised 40 percent of all uninsured adults.

Insurance Reform

The characteristics of the uninsured will be an important determinant of the impact of reforms on the health insurance market. Most of the health insurance reform proposals include a focus on the difficulty individuals and small groups have in obtaining health insurance at the same cost as larger groups. Small groups often face higher costs per participant because of their higher per capita administrative costs and insurance companies limited ability to pool risks. Insurers currently price their policies on the basis of the expected risk of the individual group. If an insurer pools all the groups it insures together and charges a premium based on that total pool, some of the groups in the pool will pay higher premiums than they would if the premiums were set on their risk alone, while others will pay lower premiums.

In the current health insurance market, insurers who attempt to pool risk across groups will find the lower risk groups will choose another insurer whose premiums reflect only their own risks and are therefore lower. By changing the incentives that keep insurers from pooling small groups, employment-based coverage may expand to include many of the employed uninsured in small firms and their dependents.

Most proposals include some means for guaranteeing that all small groups have access to insurance and are not denied coverage based on individual characteristics. However, proponents of insurance market reform recognize that guaranteed availability alone accomplishes little unless premium rates for small groups are stabilized. Some proposals move the insurance market toward community rating so that insurance would be offered to all small groups at common rates. Others would allow insurers to adjust community rates for factors such as age, sex, geographic location, and industry type (class rating).

Some analysts argue that mandating community rating or eliminating demographic adjustments would raise rates for many groups and create incentives for adverse selection. Adverse selection occurs when individuals with greater health risks are disproportionately enrolled in a particular plan or group. Community rating limits insurers ability to charge different premiums to groups on the basis of risk. As a result, premiums for groups that represent good health risks would rise with the implementation of community rating, while premiums for groups representing poorer risks would fall. Some of the healthier individuals would choose not to purchase

health insurance as a result of the premium increase, while more of those individuals who are poorer health risks would purchase health insurance. The result would be an increase in the pool's average risk, increasing premiums and potentially creating a vicious cycle that could end in an unviable health insurance market. The likelihood of this scenario actually occurring depends on the sensitivity of the demand for health insurance to changes in premiums among individuals who represent good and bad risks and on the ability of individuals to determine their own risk status.

Generally, in the managed competition models that create regional health insurance purchasing cooperatives (HIPCs), low income families, individuals not connected with a group, and employees of small employers would purchase coverage through the cooperative. These cooperatives or alliances would community rate over a risk pool formed on the basis of employer size and individual work status. The composition of these cooperatives or alliances would determine the costs of health insurance and the distribution of these costs. Even if employees of small firms are, on average, healthier than most Americans, the other two groups are likely to be less healthy. For example, table 4 provides results of simulations on the premiums likely to be charged to single adult individuals in purchasing cooperatives under different assumptions about their composition.

Table 4 estimates single adult premiums that would arise under different risk pools. In the workers only pool, all employees of firms with fewer than 500 employees are included in the pool. The estimated premium is $1,979. When nonworking individuals are added to the pool, the annual premium rises by $118, and when individuals now receiving Medicaid are added, the premium rises by another $139 to a total of $2,236. Pooling working single adults with nonworkers and Medicaid eligible individuals increases worker premiums by almost 13 percent, or an estimated $21 per month.

Managed competition models often require that employers under a certain size must purchase coverage through a risk pool formed by a regional HIPC or alliance. As table 5 indicates, increasing the size of the employer required to purchase coverage through the HIPC or alliance decreases the premium charged for coverage within that pool. Including those presently covered by Medicaid in the pool increases the average premium by an average of about 7 percent. However, simulating the per capita costs of providing coverage to nonelderly Medicaid recipients after reform indicates these costs to be $3,309. Thus, including them in the risk pools lowers the per capita costs to federal and state governments by over 29 percent.

Tables 4 and 5 assume that all individuals purchase health insurance coverage. If some individuals choose not to purchase health insurance, and if these individuals are healthier, on average, than those who elect to purchase coverage, the premiums will be higher.

Changing the way risks are pooled will have important consequences in the health insurance market. Many small groups and individuals will see the costs of health insurance fall as a result, while others will see an increase. Even those groups whose premiums will increase under some form of community rating may be better off if the reforms stabilize premiums. Small employers who currently have good risk profiles may still not offer health benefits because one catastrophic illness could make these health benefits unaffordable. Some form of community rating reduces the variability in health insurance premiums.

Reforming the health insurance market by itself is unlikely to significantly increase health insurance coverage. Although some groups may see lower premiums as a result of insurance reforms, others will face premium increases, and the stabilization of health premiums may not be enough to offset these increases. Health insurance reform will redistribute the costs of health care services from the poorer risks who may currently be excluded from the market to the better risks. The burdens imposed by this redistribution will depend on the number of good risks who remain in the pool.

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Table 1

Nonelderly and Elderly Americans with Selected Sources of Health Insurance Coverage, 1989–1992
Employee Benefit Research Institute Analysis of the March 1990, 1991, 1992, and 1993 CPS

	Total Population				Nonelderly				Elderly			
Source of Coverage	1989	1990	1991	1992	1989	1990	1991	1992	1989	1990	1991	1992
	(millions)											
Total Population	243.3	246.0	248.7	251.7	213.7	215.9	218.1	220.8	29.6	30.1	30.6	30.9
Total with Private Health Insurance	180 4	178.9	178.4	177.5	160 4	158.3	157.7	156.6	20.0	20 6	20.7	20.9
Employer coverage	150.2	148.7	150.0	148.0	140 8	138 7	139 8	138.0	9 4	10.0	10 1	10.1
Other private coverage	30.3	30.3	28.6	29.6	19 7	19 7	18.0	18.8	10 6	10 6	10.6	10.8
Total with Public Health Insurance	54 5	58 1	61.2	63 2	26.2	29 2	31 7	33 4	28.3	28 9	29 5	29.8
Medicare	31.5	32 3	32 9	33 7	3 2	3 5	3 5	4 0	28 2	28.8	29 4	29.7
Medicaid	21 1	24 2	26 8	28 5	18 5	21 6	23 9	25 6	2.6	2 6	2 9	2.9
CHAMPUS/CHAMPVA[a]	7 0	7 0	7 1	6 9	5 9	5 9	5.9	5 7	1 1	1 1	1.2	1 2
No Health Insurance	34 7	36.0	36.6	38 9	34 4	35 7	36 3	38.5	0 3	0.3	0.3	0.4
	(percentage)											
Total Population	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100 0%	100.0%	100.0%	100.0%	100.0%
Total with Private Health Insurance	74.2	72.7	71.7	70 5	75.1	73.3	72.3	70 9	67.7	68 4	67.7	67.7
Employer coverege	61.3	60 4	60.3	58 8	65 4	64 2	64 1	62.5	32.0	33.2	33.1	32 6
Other private coverage	12.4	12.3	11.5	11.8	9.2	9 1	8.2	8 5	35 7	35.2	34 7	35.0
Total with Public Health Insurance	22 4	23 6	24 6	25 1	12 3	13 5	14 5	15 1	95 8	96 0	96.3	96 6
Medicare	12 9	13 1	13 2	13 4	1 5	1 6	1 6	1 8	95 6	95 7	96 0	96 2
Medicaid	8 7	9 8	10 8	11 3	8.7	10 0	11 0	11 6	8 7	8 6	9 5	9 4
CHAMPUS/CHAMPVA[a]	2.9	2 8	2 9	2 7	2 8	2.7	2 7	2 6	3 7	3 7	3 8	3 9
No Health Insurance	14 3	14.6	14 7	15 4	16 1	16 5	16 6	17 4	1.0	1.0	0.9	1.2

Note: Details may not add to totals because individuals may receive coverage from more than one source.

[a]Includes only the retired military and members of their families provided coverage through the Civilian Health and Medical Program for the Uniformed Services and the Civilian Health and Medical Program of the Veterans Administration. Excludes active duty military personnel and members of their families.

Table 2

Nonelderly Population with Selected Sources of Health Insurance, by Firm Size of Family Head's Employer, 1992
Employee Benefit Research Institute Analysis of the March 1993 CPS

Firm Size of Family Head's Employer	Total	Total Private	Employer Coverage			Other Private	Total Public	Medicaid	No Health Insurance Coverage
			Total	Direct	Indirect				
					(millions)				
Total	220 8	156.6	138.0	68 9	69 1	18 8	33 4	25.6	38.5
Nonworker	25 7	6.6	4 1	2.7	1 5	2.5	14 3	12 2	6.0
Fewer than 10	32 3	19.5	12.5	5 8	6.7	7.0	3.6	2.8	9.8
10–24	16 4	10 4	8.8	4.3	4.5	1 6	1 9	1.6	4.4
25–99	26.8	19.2	17.3	8 8	8 5	1.9	2 8	2 1	5.5
100–499	29.7	23 6	22.2	11.1[1]	11.1	1.4	2 8	2.1	4.2
500–999	11.7	9 8	9 3	4 5	4.7	0 6	1.0	0 7	1.3
1,000 or More	78.3	67.4	63.7	31 6	32 1	3 8	6 9	4 0	7.2
					(percentage within coverage categories)				
Total	100 0%	100.0%	100.0%	100.0%	100 0%	100.0%	100.0%	100.0%	100.0%
Nonworker	11.6	4.2	3.0	3 9	2 1	13 5	42 9	47.7	15.6
Fewer than 10	14 6	12 5	9 1	8 5	9 7	37.5	10.9	11.0	25 5
10–24	7 4	6 6	6 4	6 2	6 5	8 5	5 8	6 1	11.5
25–99	12 1	12.2	12.6	12 8	12 3	9 9	8 4	8 4	14.4
100–499	13 4	15.1	16.1	16.2	16.1	7.6	8 4	8.2	10.9
500–999	5.3	6 3	6.7	6.6	6.9	3.0	3.0	2.9	3 3
1,000 or More	35.5	43 1	46.2	45.9	46.4	20.1	20.6	15.8	18.8
					(percentage within firm size categories)				
Total	100.0%	70.9%	62 5%	31.2%	31 3%	8 5%	15 1%	11.6%	17.4%
Nonworker	100.0	25.8	16.0	10.3	5.7	9 9	55.7	47 6	23.4
Fewer than 10	100.0	60.4	38 8	18 0	20 7	21 8	11 3	8 7	30.4
10–24	100.0	63 1	53 4	26 1	27 3	9 8	11 9	9 5	27.0
25–99	100.0	71.7	64 8	32 9	31 9	7 0	10 4	8 0	20.7
100–499	100 0	79 6	74 9	37 5	37 4	4 8	9 5	7.0	14.2
500–999	100.0	84.3	79 6	38 9	40 7	4 8	8 6	6 3	11.0
1,000 or More	100 0	86 1	81 4	40 4	41.0	4 8	8.8	5.2	9.2

Note: Details may not add to totals because individuals may receive coverage from more than one source

Table 3

Nonelderly Population with Selected Sources of Health Insurance Coverage, by Family Income as a Percentage of Poverty, 1992, Employee Benefit Research Institute Analysis of the March 1993 CPS

Family Income as a Percentage of Poverty	Total	Total Private	Employer Coverage			Other Private	Total Public	Medicaid	No Health Insurance Coverage
			Total	Direct	Indirect				
					(millions)				
Total	220.8	156.6	138.0	68.9	69.1	18.8	33.4	25.6	38.5
0–99%	33.0	6.1	3.6	1.5	2.1	2.5	17.2	16.4	10.8
100%–124%	9.8	4.0	3.1	1.2	1.9	0.9	2.9	2.5	3.5
125%–149%	9.6	4.7	3.7	1.5	2.2	0.9	2.0	1.6	3.4
150%–199%	20.2	12.6	10.7	4.5	6.2	1.8	3.0	2.0	5.6
200%–399%	74.7	61.8	55.6	25.5	30.1	6.3	5.2	2.5	10.4
400% or More	73.5	67.5	61.3	34.7	26.6	6.3	3.1	0.7	4.9
					(percentage within coverage categories)				
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
0–99%	15.0	3.9	2.6	2.1	3.0	13.4	51.5	63.9	28.1
100%–124%	4.4	2.5	2.2	1.7	2.7	4.8	8.6	9.6	9.0
125%–149%	4.4	3.0	2.7	2.2	3.2	5.0	6.0	6.4	8.8
150%–199%	9.1	8.0	7.8	6.5	9.0	9.7	9.0	8.0	14.5
200%–399%	33.8	39.5	40.3	37.0	43.5	33.6	15.4	9.7	26.9
400% or More	33.3	43.1	44.4	50.4	38.5	33.4	9.4	2.5	12.7
					(percentage within poverty status categories)				
Total	100.0%	70.9%	62.5%	31.2%	31.3%	8.5%	15.1%	11.6%	17.4%
0–99%	100.0	18.4	10.8	4.5	6.4	7.6	52.0	49.5	32.7
100%–124%	100.0	40.4	31.3	12.3	19.0	9.3	29.3	25.1	35.6
125%–149%	100.0	48.5	38.8	15.5	23.3	9.9	20.9	16.9	35.3
150%–199%	100.0	62.2	53.2	22.3	30.9	9.1	14.8	10.1	27.7
200%–399%	100.0	82.7	74.4	34.1	40.2	8.5	6.9	3.3	13.9
400% or More	100.0	91.9	83.4	47.2	36.2	8.5	4.3	0.9	6.7

Note: Details may not add to totals because individuals may receive coverage from more than one source

Table 4

Simulation of Single Adult Premiums under Various Assumptions of Composition of Risk Pool. Assumes All Employees of Employers with Fewer Than 500 Employees Purchase Coverage through Health Insurance Purchasing Cooperative (HIPC), All Other Employees Purchase Coverage Outside HIPC

Composition of Risk Pool	Premiums Outside HIPC	Premiums Inside HIPC
Workers Only	$2,188	$1,979
and Nonworkers	$2,018	$2,097
and Medicaid	$1,683	$2,236

Source: Employee Benefit Research Institute simulations using the March 1993 supplement to the Current Population Survey and the National Medical Expenditure Survey.

Table 5

Simulated Single Adult Premiums Under Various Assumptions on Size of Employer in Risk Pool and Whether Medicaid Recipients are Included in the Pool

Composition of Risk Pool	Employer Size Cap		
	100	500	1,000
Medicaid Out	$2,181	$2,097	$2,068
All Under Cap In	$2,336	$2,236	$2,202

Source: Employee Benefit Research Institute simulations using the March 1993 supplement to the Current Population Survey and the National Medical Expenditure Survey.

PREPARED STATEMENT OF SENATOR DAVE DURENBERGER

Mr. Chairman, I thank you for recognizing that insurance reform is the fundamental building block of comprehensive system reform. This committee is very familiar with this subject as we have held past hearings, marked up legislation and subsequently passed it on the Senate floor twice.

Looking back, it is unfortunate that we are not starting the second session of the 103rd Congress to build on the small group insurance reform provisions that could have been already implemented. Today, Americans would be seeing results in the system. Maybe the examples given by the President in his speech last week could have been addressed by insurance reform.

Under your leadership, Mr. Chairman, I am certain that we will not be looking back again with wishful thinking on this subject. Instead we will move forward.

Recently, there has been much discussion as to whether there is a health care crisis. Regardless of one's view, I believe we all can recognize that we have a system which has a host of difficult and interrelated problems that are showing up in the pain and uncertainty that every member has felt from millions of American families and businesses.

I first became involved in insurance market reform in 1990, when my experience with Minnesota small businesses and farmers told me something was very wrong in the insurance market. I saw that the price and quality of insurance coverage was related to where you worked.

As soon as we finished our work on the Pepper Commission in March of 1990, people on my staff—particularly Kathy Means, who is now at HCFA, and Dave Gustafson, who was then on loan from PBGC and is now back at PBGC—went to work to design appropriate insurance reform, because we thought we could get 75 percent of the way to the charge of the Pepper Commission.

I introduced the first product of their work in S. 3260 in October of 1990. The refined product was S. 700 in 1991. And later that year it was incorporated into S. 1872—legislation I introduced with our previous Chairman, Secretary Bentsen. It was also included in my Republican colleagues' bill, led by John Chafee; and it is in a lot of bills around here.

We have all the reform packages on the table now. We have the President's, Chafee/Dole, Nickles, Gramm, and Breaux/Durenberger; a variety of them. Despite their differences, there is a strong consensus on one issue—reform of insurance in the small group market.

The real problem of access to health care is that people cannot gain financial access to the system because medical costs are too high and there is unequal access to insurance coverage.

Nowhere is that problem more severe than among people who are self-employed or work in small businesses. In almost every case these people pay far higher premiums for far less coverage than employees of large and medium-sized firms.

When we realize that over 50 percent of American workers are either self-employed or work in small businesses, we begin to see the extent of this problem.

Among the 37 million uninsured, and the much larger group of the "under-insured," a substantial majority of them are small business employees, self-employed people and their dependents.

Big companies get good coverage at reasonable prices. Little companies get insufficient coverage at high rates and are subject to exorbitant price increases and cancellation without warning.

There are many problems in need of solutions within the current delivery system. However, insurance reform gets to about 75 percent of the coverage issue. It will not do it all, but it is an important step in getting us there. And that is the reason that I have invested much time over the last five years in this particular issue.

In my view, in order to achieve universal access to high quality care through universal coverage of financial risk, we have only two choices. One way is by setting a budget and achieving savings through fee reductions and premium caps. That approach will sacrifice quality for spending reductions. The better way is to focus on productivity—how to get more health care for less. Productivity is the American way.

We need to encourage all the actors in the health care system—insurers, consumers, providers, employers and government—to become more productive. We must design systems that reward the good providers and the good health plans with our business.

Mr. Chairman, we've got a long journey in front of us to arrive at comprehensive health reform. This is an excellent place to start. It addresses a major problem and there is substantial bipartisan agreement. I commend you for getting us underway.

PREPARED STATEMENT OF BILL GRADISON

Good morning, Mr. Chairman and Members of the Committee. My name is Bill Gradison; I am President of the Health Insurance Association of America (HIAA). HIAA represents approximately 236 commercial health insurers, covering approximately 55 million Americans.

Mr. Chairman, our nation's health care system requires comprehensive reform. Although most Americans are adequately protected by their health insurance, many are not. Approximately 37 million Americans have no health insurance coverage, and health care costs are consuming an ever greater share of the gross domestic product. There can be no doubt about the need for comprehensive reform.

Mr. Chairman, HIAA believes that health care reform should lead to universal coverage for a federally defined benefit package. No one should lose coverage because they get sick, change jobs, or lose their job. Competition among health plans should be based on quality and efficiency.

We wholeheartedly agree with the six principles for health care reform endorsed by the President: security, simplicity, quality, savings, choice and responsibility. HIAA has proposed specific means by which they can be achieved. Let me emphasize what HIAA supports:

- "Cradle-to-grave" coverage for all Americans;
- No exclusions for existing or previous illness;
- Coverage that cannot be canceled if you get sick;
- If you change jobs or lose your job, coverage goes with you;
- Employers and employees both pay toward coverage;
- Subsidies for those who cannot afford premiums;
- Reform of malpractice laws and reduction in defensive medicine;
- Publication of price and quality data to allow accurate, easy comparisons;
- A single claim form to control paperwork;
- Incentives for healthy lifestyles, with emphasis on wellness and prevention;
- Elimination of cost-shifting from Medicaid and Medicare to those with private insurance;
- Use of managed care to control costs and enhance quality.

ASSURING UNIVERSAL CONTINUOUS COVERAGE

Mr. Chairman, as you requested, the remainder of my testimony focuses on HIAA's suggestions for reform of the health insurance market. As you know, many states have already enacted some insurance reforms; appended to my testimony is a chart outlining those state reforms.

As we discuss the specifics of proposals for federal reform of the health insurance market, it is important to recognize that changes in the health care system are interconnected. My suggestions today pertain strictly to an environment in which there is universal coverage, achieved through an individual and an employer mandate, with government subsidies available for those who cannot afford to purchase the federally defined benefit package: Medicare would remain in place. Without universal coverage, the same rules may not achieve the intended goals and may, in fact, have unintended, adverse effects.

A federally defined benefit package should be established. The package should be flexible to encourage cost-conscious behavior. Americans should be encouraged to take personal responsibility for maintaining good health regarding lifestyle factors within their control.

The HIAA endorses the following health insurance market reforms:

- Insurers and other private payors must issue and renew coverage for all;
- Coverage must be continuous: there must be no preexisting condition limits once an individual is in the system; and the problem of "job lock" must be eliminated;
- Coverage must be made available to every employee in an employment-based group, regardless of health status. No one in a group could be excluded;
- Coverage cannot be canceled, terminated or not renewed based on the health status or claims experience of any individual or group;
- Rating restrictions should be established so that large rate differentials for groups of similar age, sex and geographic composition do not exist. We oppose "pure" community rating because it results in market disruption and works against cost containment in a variety of ways;
- A system of reinsurance or risk-sharing for individual and small group insurance must be established to compensate for inequitable distribution of risk. There will be no advantage to selecting good risks. This will eliminate concerns about "cherry-picking;"

- To protect consumers from the risk of financially unstable carriers, and to maintain employer incentives to control costs and promote employee wellness, insurers within limits, should be allowed to establish premium rates that provide incentives for healthy lifestyles and managing care;
- A standardized, "paperless" system should be developed through the use of a uniform claims form and electronic data interchange.

It is also important, Mr. Chairman, that these reforms apply equally to insured and self-insured plans. Employers who choose to self-insure essentially become "carriers," and must do their part to ensure that all Americans have access to continuous coverage for a federally defined benefit package. There should be parity in the marketplace.

SPECIAL RULES FOR THE INDIVIDUAL AND SMALL GROUP MARKET

Because we recognize that individuals and small employers currently face serious problems in the marketplace, HIAA recommends that more stringent insurance reforms be applied to carriers in those markets.

Under a system of universal coverage, we recommend that insurers operating in the individual market be required to "guarantee issue"—carriers must issue the defined benefit package to any individual who wants to purchase it, as long as the individual is not eligible for group coverage through an employer or a government program. Similarly, in the small group market (2 to 50 employees), insurers must "guarantee issue" the defined benefit to any small employer group that applies for it.

Second, small employers and individuals require a rating system that shields them from the year-to-year variability in health care costs. In a system of universal coverage, carriers selling to individuals or small employers should be required to use modified community rating. Permitted rating classes should include family size, geographic location, age, gender and health improving behaviors (e. g., non-tobacco use). But neither the health status nor the claims experience of an individual or employee of a small employer would be considered in determining premiums.

In contrast, Mr. Chairman, the aggregate claims experience for larger groups is quite stable. Allowing variation in rates for larger groups based on experience encourages employer involvement in cost containment efforts and in improving the health status of employees.

Recognizing that some insurance companies, because of historical focus, are not equipped to provide coverage to groups of all sizes, insurers should not be required to serve market segments (based on group size) in which they have no expertise.

RISK ADJUSTMENT IN THE INDIVIDUAL AND SMALL GROUP MARKETS

To eliminate carriers' incentives to seek out healthy enrollees and avoid unhealthy enrollees, particularly in an environment where carriers are not allowed to associate the premium charged fully with the costs they expect to incur, a risk adjustment or reinsurance mechanism is needed. Health care costs vary more among individuals than among groups and more among small groups than among large groups. This is because virtually any employer group that happens to have some unhealthy people will also have some healthy ones. A risk adjustment mechanism in this market is designed to ensure that individual and small group carriers aren't disadvantaged if they happen to get a larger-than-average share of people with significant medical problems. similarly, a risk adjustment mechanism will ensure that one carrier does not benefit if it enrolls a healthier mix of people than its competitors.

We recommend that carriers competing in a defined geographic market area be required to participate in a common risk adjustment mechanism.

I would note that these rules are intended to apply to health benefit plans for medical expenses—not to other types of coverages, such as disability insurance, Medicare supplemental policies, and other plans that cover services not included in a federally defined benefit package.

MARKETING PRACTICES

Although a risk adjustment or reinsurance mechanism reduces incentives for carriers to seek out good risks while avoiding bad risks, further safeguards should be provided through the regulation of marketing practices. These marketing rules would prevent carriers from engaging in risk selection through selective marketing, service or delivery of care, and ensure that marketing is based on accurate and uniform (comparable) cost and quality measures.

HIAA recommends that carriers conform with defined fair market practices. In all aspects of their marketing and business operations, carriers should not be allowed

to discourage enrollment of any applicant, or encourage disenrollment of any insured, based on a person's health status or claims experience. Carriers should be required to provide specified cost and quality data to a designated agency.

"Tying" the sale of the federally defined benefit package to the purchase of another insurance or financial services product should be strictly prohibited.

We also believe that agents and brokers play an important role in the health insurance system. Individuals and employers of all sizes should be free to use agents to assist in selecting, purchasing and servicing of health insurance plans.

Finally, to ensure that all Americans are guaranteed access to continuous coverage, the financial solvency of insurers and others providing protection must be subject to appropriate regulation. All carriers and self-insured employers should be required to meet solvency requirements.

PURCHASING COOPERATIVES/HEALTH ALLIANCES

Mr. Chairman, as you know, many people believe that some type of "purchasing cooperative" or "health alliance" can be helpful in restructuring our nation's health care system. A few states have authorized the creation of these mechanisms. Proponents suggest that purchasing groups may be helpful to some individuals and small employers—and that may be true. But we won't know one way or the other until these mechanisms are thoroughly tested to determine whether they achieve administrative savings or enhance small employer and individual bargaining power.

Mr. Chairman, HIAA strongly objects to *requiring* any portion of the American public to obtain its health coverage through an alliance. The President's proposal would result in approximately three-quarters of the American people being forced into these untested alliances.

HIAA recommends that, if alliances are to be established, they should be voluntary: employers and individuals should have the option of purchasing their coverage through the alliance or maintaining their current coverage. All health plans, whether or not they participate in the health alliance, would have to play by the same rules, so that neither the alliance nor plans operating outside the alliance would receive an inequitable share of risk. Insurance reforms and marketing rules, such as those discussed previously, would apply to plans offered both inside and outside the alliance.

If health alliances are truly more administratively efficient, and better at pooling risks, then the carriers operating through alliances will have lower premiums and will naturally gain market share. If, on the other hand, employers and individuals feel they are better served in dealing directly with an insurance company rather than a large government bureaucracy, they should have that choice. The market, not the government, should determine which is the more efficient way to insure all Americans. A voluntary approach would provide the opportunity to test alliances, without needlessly placing American health care at risk. Under a mandatory alliance approach, where will the millions of Americans go if the system doesn't work? The infrastructure that previously served them would no longer exist.

ACTUARIAL ESTIMATE OF THE BENEFITS PACKAGE

Finally, Mr. Chairman, one of HIAA's actuaries recently completed his analysis of the cost of the benefit package included in the President's Health Security Act. I wanted to share that with you today. A copy of the estimate is appended to my testimony, and I ask that it be included in the record. In brief, the analysis suggests that the Administration may have significantly underestimated the insurance premiums that individuals and families would have to pay if the President's health care reform proposal were in effect today. This study is the first formal, peer-reviewed, actuarial opinion to be released regarding the reasonableness of the Administration's premium estimates.

According to our analysis, which uses data supplied by HIAA member companies, single persons would pay $2,358 to $2,632 per year for insurance coverage under the White House proposal, while two-parent families would pay $6,840 to $7,634 for coverage. According to Clinton Administration estimates, individual premiums would cost $1,932 and family premiums would cost $4,360. On average, the Administration's estimates of premiums incurred after full implementation of the Health Security Act are understated by nearly one-third.

Again, Mr. Chairman, I want to thank you for the opportunity to share HIAA's views with you. I would be happy to answer any questions.

HIAA

November 8, 1993

Health Insurance Association of America

SMALL EMPLOYER PACKAGES

	ALASKA	ARIZONA
Availability	Guaranteed issue. Director may promulgate regulations to require insurers after July 1, 1993 to reissue plans that small employers had terminated after January 1, 1993. §21.56.190 (1993 SB 173)	Guaranteed offer (group size 25-40, beginning 7/1/96 3-40 lives) §20-2304
Group Size	2-25 §21.56.250(23)	3-40 §20-2301(E)
Individual Policies	Individual policies sold to small employers meeting certain requirements are subject to this Act. §21.56.110	Does not apply to any policy that is issued on an individual basis §20-2302(B)
Case Characteristics	Age, sex, industry, geographic area, family composition and group size. Others need director approval. May not use claim experience, health status, and duration of coverage. 21.56.120	Does not include claims experience, health status, industry or duration of coverage. §20-2301(2)
Rating Restrictions	Premium rates for small employer plans with similar case characteristics for similar coverage may not vary from the index rate by more than 35%. §21.56.120	Premium rates may not vary by more than 60% from the index rate for plans with similar coverage, family size and composition and geographic area. Plans making adjustments for demographic characteristics shall apply them consistently across all employers. Prohibits using geographic areas smaller than a county or an area that includes all areas in which the first three digits of the zip code are identical, whichever is smaller. §20-2311
Transitional Period	3 years §21.56.120 amended by §10	
Renewal Rating	Trend plus 15% plus changes in case characteristics. §21.56.120	Trend plus 15% plus any adjustment in case characteristics §20-2311(C)
Renewability	Guaranteed renewable except "for cause." §21.56.130	Guaranteed renewable except "for cause" §20-2309
Whole Groups	Must cover whole group. §21.56.150(6)	Carriers are required to take the whole group. No regard given to health status or insurability. §20-2307
Continuity of Coverage	Preexisting condition limitation of 12 months relating to conditions 6 months before coverage. Waiting periods must be waived for the period of time an individual was previously covered if that coverage was continuous 90 days before effective date of new coverage. The period of continuous coverage may not include a waiting period for the effective date of coverage applied. §21.56.150(2)	Preexisting condition limitation of 12 months; credit of one month for each month of continuous coverage for 60 days under another plan prior to new coverage. §20-2310
Reinsurance type	Prospective. Membership a condition of doing health insurance business. §21.56.010	Prospective/with opt out §20-2345
Reinsurance Price	Whole Groups: 150% Individual: 500% §21.56.050	Whole group: 150% Individual: 500% §20-2350
Cost Sharing	Association may not reimburse a reinsuring insurer until insurer has paid an initial level of $5000 per year. §21.56.050	$5000 plus 10% of the next $50,000 and a cap of $10,000 per year. §20-2349
Assessments	Board shall determine. Insurers may not have an assessment share less than 50% or more than 150% of the proportion of total premiums earned the preceding year from small group plans. Assessments above 5% of total premiums will be evaluated. §21.56.050	Board shall determine. §20-2351
Other	Repealer on 7/1/98 §12 Prohibits cost shifting of the program to other insureds or the state. §21.56.040	
Effective Date	July 1, 1993	December 31, 1993

	ARKANSAS	CALIFORNIA
Availability		Guaranteed issue of small employer products (group size 5-50 by 7/1/93; 4-50 by 7/1/95) (1192 HB 1672)
Group Size	1-25 §23-86-202	3-50 §10700(x)
Individual Policies	Does not apply to individual policies which are subject to policy form and premium rate approval. §23-86-203	Individual policies sold to small employers meeting certain requirements are subject to this Act. §10702
Case Characteristics	Relevant demographics of small employer as considered by carrier in determination of premiums. Claims experience, health status, and duration of coverage are not case characteristics. §23-86-202	Includes age (7 categories), geography (9 regions), family composition (4 categories), and plan design which are used to determine the standard employee risk rate. §10700(w)
Rating Restrictions	Index rate for one class of business shall not exceed the index rate for any other class of business by more than 20%. §7204(a). For a class of business, the premium rates charged small employers with similar case characteristics shall not vary from the index rate by more than 25%. §23-86-204	Premium rates may not vary from the standard employee risk rate by more than 120% nor less than 80% until July 1, 1996; effective July 1, 1996, premium rates may not vary from the standard employee risk rate by more than 110% nor less than 90%. §10700(v), 10714
Transitional Period	5 years §23-86-204	See above
Renewal Rating	Trend plus 15% plus changes in case characteristics. §23-86-204	10% permitted for risk adjustment factors; renewal rates are effective for at least six months §10714(b)1(2)
Renewability	Guaranteed renewable except "for cause." §23-86-205	Guaranteed renewable except "for cause" §10705(b), 10713
Whole Groups		Carriers are required to take the whole group. §10707
Continuity of Coverage		Preexisting condition limitation of 6 months; credit shall be given if a person was covered under qualifying previous coverage if previous coverage was continuous 30 days prior to the new coverage, exclusive of applicable waiting periods; if employment is terminated or employer's contribution toward the coverage has terminated, there is a 90-day period allowed for continuity of coverage. §10706, 10708(a,b), 10709(a)
Reinsurance type		Prospective/with opt out §10719, 10720(d)
Reinsurance Price		No provision
Cost Sharing		No provision
Assessments		No cap §10721
Other		Establishes a purchasing pool for small employers §10730 Guaranty Association - only need one member
Effective Date	January 1, 1992	July 1, 1993, but see phase-in effective dates above

	COLORADO	CONNECTICUT
Availability		Guaranteed issue §38a-552, 5682(b) (*1992 SB 419 changes)
Group Size	1-25 §10-8-101	1-25 §38a-564(4)
Individual Policies	Does not apply to individual policies. §10-8-101(5)	Insurers may issue individual special health care plans subject to the laws applicable to individual health insurance, provided such policies shall be identical to individual special health care plans made available by the Health Reinsurance Association. §38a-552, 566
Case Characteristics	Prohibits an insurer from requesting medical information which is more than 5 years old on any of the enrolled members of a small group in underwriting or setting premiums for the group. May use current health status §10-8-116.5(7)	Appears to include everything except claims experience, duration of coverage and health status. §38a-564(27)
Rating Restrictions	silent	Premium rates may not exceed 200% of the base premium rate for the same or similar case characteristics for plans issued on or after 7/1/90 and prior to 10/1/92 and beginning 7/1/95 plans issued prior to 7/1/90. Rates may not exceed 150% of the base premium rate for plans issued on or after 10/1/92, and beginning 10/1/97, plans issued prior to 10/1/92.* §38a-567(5)
Transitional Period	silent	5 years, after July 1, 1995, rating restrictions will be applied to plans issued prior to July 1, 1990 §38a-567(5)
Renewal Rating	Trend plus 15% plus changes in case characteristics. §10-8-116.5	Trend plus 15% plus changes in case characteristics * §38a-567(6)
Renewability	Guaranteed renewable except "for cause." §10-8-116.5	Guaranteed renewable except "for cause" §38a-567(3)
Whole Groups		Cannot exclude eligible employees or dependents on the basis of an actual or expected health condition §38a-567(4)
Continuity of Coverage		Preexisting condition limitation of 12 months; credit shall be given if a person was covered under qualifying previous coverage if previous coverage was continuous 30 days prior to the new coverage, exclusive of applicable waiting periods, except a carrier may limit the credit for a person enrolled commencing before 8/1/92 to prior coverage as a resident of CT. §38a-567(1,2)
Reinsurance type		Prospective/mandatory (effec. 5/1/91) §38a-569
Reinsurance Price		Whole Group: 150% Individual: 500% §38a-569(c)
Cost Sharing		$5000 for all plans except those which supplement the basic hospital or hospital surgical plans, in which case the deductible is $2000 §38a-569(b1)
Assessments		(1) Apportioned among all members in proportion to their respective shares of the total premiums earned from small group plans, (2) apportioned among all members in proportion to their respective shares of total premiums earned from other plans; members' assessments cannot exceed 40% of the total assessment for the first year; 50% for the second §38a-569 e(2)
Other		
Effective Date	July 1, 1991	July 1, 1990

	DELAWARE	FLORIDA
Availability	Guaranteed issue (groups of 2-25) §7207(a)3	Guaranteed issue with cap (group size 3-25) (1992 SB 2390) §627.6699(3)r, (5)a
Group Size	1-25 §7202(cc)	1-25 §627.4106(2)a (Jan. 1, 1994 changes to 1-50)
Individual Policies	Applies to any health benefit plan provided by a small employer which provides coverage to the employees of such small employer in this state. §7203	Generally applies to individual policies sold to small employers. With regard to rating and renewability provisions, does not apply to individual policies if the insurer certifies to the department that the policy was issued in good faith with no knowledge or intent that the policy is paid by or the premiums are reimbursed by a small employer §627.4106(4) (Applies to individuals 4/94)
Case Characteristics	Demographic or other objective characteristics of small employer as considered by carrier in determination of premiums; Claims experience, health status, and duration of coverage are not case characteristics; small employer carrier shall not use characteristics other than age, gender, industry, geographic area, family composition, unhealthy lifestyle choices, and group size without prior approval of Commissioner §7202(g), 7204, 7205(4)	Demographic or other objective characteristics of small employer as considered by carrier in determination of premiums; Claims experience, health status, and duration of coverage are not case characteristics §627.4106(2)e (1/1/94 rating factors are age, gender, family comp., tobacco usage and geography)
Rating Restrictions	Index rate for one class of business may not exceed the index rate for any other class of business by more than 20%; for a class of business, the premium rates charged small employers with similar benefit plans shall not vary from the index rate by more than 35%, with an additional combined variation of no more than 10% for gender and geography, and the actuarially justified adjustment for age and family composition, provided that the carrier file age and family composition tables with the Commissioner §7205(1,2)	Index rate for one class of business may not exceed the index rate for any other class of business by more than 20%; for a class of business, the premium rates charged small employers with similar case characteristics shall not vary from the index rate by more than 25% §627.4106(5)1,3 Expires 1/1/94.
Transitional Period	For plans delivered or issued for delivery prior to the effective date of this chapter, a premium rate may have a one-year transition period §7205(7)	5 years §627.4106(9)
Renewal Rating	Trend plus 15% plus changes in case characteristics §7205(3)6	Trend plus 15% plus changes in case characteristics §627.4106(5)b
Renewability	Guaranteed renewable except "for cause" §7206	Guaranteed renewable except "for cause" §627.4106(6)
Whole Groups	Carriers must offer coverage to all eligible employees and dependents §7207(a)	Carriers must offer coverage to all eligible employees and dependents §627.6699(5)e(7)
Continuity of Coverage	Preexisting condition limitation of 12 months; credit shall be given if a person was covered under qualifying previous coverage if previous coverage was continuous 60 days prior to the new coverage, exclusive of applicable waiting periods §7207(c)	Preexisting condition limitation of 12 months; credit shall be given if a person was covered under qualifying previous coverage if previous coverage was continuous 30 days prior to the new coverage, exclusive of applicable waiting periods §627.6699(5)e(1)(2)
Reinsurance type	Prospective/with an opt-out §7210	Prospective/with an opt-out §627.6699(8)
Reinsurance Price	Whole Group: 150% Individual: 500% §7210(i)4	Whole Group: 150% Individual: 500% §627.6699(8)h(1)a,b
Cost Sharing	$5,000 plus 10% of the next $50,000 §7210(L)2b, (L)3c	$5000 per year plus 10% of incurred claims during a calendar year §627.6699(8)9(4)
Assessments	Formula to be set by Board but must be 50% - 150% of carrier's proportional share of all reinsuring carriers' small employer premiums; maximum amount shall be 5% of total premiums earned in previous year from small employer plans §7210(L)2(b), L(3)c	1st tier: an amount not to exceed 5% of small employer premiums; 2nd tier, if necessary: an amount not to exceed .5% of premiums collected on all health benefit plans issued by small and large group carriers §627.6699(8)J(2)
Other	Allows reinsurance of existing business §7210(i)3	Carriers paying 2nd tier assessments will receive a credit for assessments paid to the Florida Risk Pool §627.6699(8)J(2)b
Effective Date	January 4, 1993	October 1, 1992 (rating & renewability provisions 10/1/91)

	GEORGIA
Availability	
Group Size	1-50 §33-27-8(a)
Individual Policies	Silent
Case Characteristics	Age, sex, area, industry, occupation and avocational factors may be considered. "Duration since issue and their factors may not be considered." §33-27-8(d)
Rating Restrictions	The claims experience produced by small groups covered under "group life" insurance for each insurer shall be fully pooled for rating purposes. The claims experience provided by any individual small group shall not be used in any manner for rating purposes §33-27-8(b), but see §33-27-8(d) which states that not withstanding subsection (b) the total premium calculated for any small group may deviate from the pool rate by not more than + or - 25% based upon individual small group experience factors. §33-278(d)
Transitional Period	Silent
Renewal Rating	Substandard rating shall not be used for renewability purposes. §33-27-8(d)
Renewability	The claims experience produced by any individual small group shall not be used solely as a reason for termination of any individual small group. §33-27-8(b)
Whole Groups	
Continuity of Coverage	
Reinsurance type	
Reinsurance Price	
Cost Sharing	
Assessments	
Other	
Effective Date	October 1, 1990

	HAWAII	IDAHO
Availability	State run, employment based program; all residents are eligible	Guaranteed issue (2-50). §41-4708(c)
Group Size	No provision	1-49 §41-4703(28)
Individual Policies	No provision	Does apply to individual policies. §41-4704
Case Characteristics	No provision	Demographic or other objective characteristics of small employer as considered by carrier in determination of premiums; Claims experience, health status and duration of coverage are not case characteristics. §41-4703(8).
Rating Restrictions	No provision	Index rate for one class of business may not exceed the index rate for any other class of business by more than 20%; for a class of business, the premium rates charged small employers with similar case characteristics shall not vary from the index rate by more than 25% Carriers shall not use case characteristics, other than age or gender, without prior approval of the director. §41-4706
Transitional Period	No provision	3 years §41-4706(f)
Renewal Rating	No provision	Trend plus 15% plus changes in case characteristics §41-4706(c)
Renewability	No provision	Guaranteed renewable except "for cause" §41-4707
Whole Groups	No provision	Carriers are required to take the whole group. §41-4708(3)e
Continuity of Coverage	No provision	Preexisting condition limitation of 12 months; Credit given if a person was covered under qualifying previous coverage if that coverage was continuous 30 days prior to the new coverage, exclusive of applicable waiting periods §41-4708(3)
Reinsurance Type	No provision	Prospective/with an opt-out §41-4709
Reinsurance Price	No provision	Whole Group: 150% Individual: 500% §41-4711(10)b
Cost Sharing	No provision	$5,000 plus 10% of the next $50,000 of incurred claims during a calendar year. §41-4711(9)
Assessments	No provision	Determined by Board. §41-4711(12)e
Other	Employees required to pay 1.5% of wages, or half the premium whichever is less; employers provide the balance for each employee working more than 20 hours per week; dependent coverage is optional; unemployed residents above poverty level pay a small fee for doctor visits and a portion of the premium with the remainder being funded by the State; poor are covered by Medicaid	
Effective Date		July 1, 1993

	INDIANA	IOWA
Availability		Guaranteed issue §513(B)
Group Size	3-25 IC 27-8-15(14)	1-25; however, must have at least 2 participating employees at the date of issue of health benefit plan §513B.2(12)
Individual Policies	Does apply to individual policies IC 27-8-15(2)	Does apply to individual policies which are subject to policy form and premium rate approval. §513B.3
Case Characteristics	Relevant demographics of small employer as considered by carrier in determination of premiums. Claims experience, health status, and duration of coverage are not case characteristics. IC 27-8-15(6)	Include age, industry classification, geographic area, family composition, and group size; gender may be used provided the insurance division has conducted an independent, actuarial study that determined use of gender shall to be actuarially justified, other case characteristics shall not be used without prior approval of commissioner. §513B.2(4)
Rating Restrictions	For a small employer business, the premium rates charged small employers with similar case characteristics for the same or similar benefit design characteristics may not vary from the midpoint rate by more than 35% IC 27-8-15(16)(1)	Index rate for one class of business shall not exceed the index rate for any other class of business by more than 20%, for a class of business, the premium rates charged small employers with similar case characteristics shall not vary from the index rate by more than 25% §513B.4
Transitional Period	5 years IC 27-8-15(16)(3)	3 years §513B.4
Renewal Rating	Trend plus 15% plus changes in case characteristics. IC 27-8-15(16)(2)	Trend plus 15% plus changes in case characteristics. §513B.4
Renewability	Guaranteed renewable except "for cause." IC 27-8-15(19)	Guaranteed renewable except "for cause." §513B.5
Whole Groups		Must offer to whole group, except as permitted with regard to late enrollees. §513B.7A(3)e
Continuity of Coverage		Preexisting condition limitation of 12 months, credit shall be given if a person was covered under qualifying previous coverage if previous coverage was continuous 30 days prior to the new coverage, exclusive of applicable waiting periods. §513B.7A(3)3
Reinsurance type		Prospective with an opt-out §513B.7(D)
Reinsurance Price		Whole Group: 150% Individual: 500% §513B.7(D)9(b)
Cost Sharing		$5,000 and 10% of the next $50,000 of incurred claims during a calendar year; liability maximum of $10,000 in any one calendar year with respect to any reinsured individual. §513B.7(D)8(D)
Assessments		Formula to be set by Board but must be 50%-150% of carrier's proportional share of all reinsuring carriers' small employer premiums; amount shall be 5% of total premiums earned in previous year from small employer plans. §513B.7(D)11(2)
Other		
Effective Date	June 30, 1992	July 1, 1992

	KANSAS	LOUISIANA
Availability	Guaranteed issue (group size: 3-25) (1992 SB 561) §4(b), 12(a)	
Group Size	1-25 §3(z)	1-35 §22:228.1
Individual Policies	Individual policies issued to individuals and dependents totally independent of any group, association, or trust arrangement shall not be subject to this Act §4(a), 4(a)3(c)	Silent
Case Characteristics	Case characteristics include the geographic area, age and sex, industry classification, number of employees and dependents, family composition, and other objective criteria as may be approved by the commissioner; claims experience, health status, and duration of coverage are not case characteristics §3(g)	Relevant demographics of small employer as considered by carrier in determination of premiums. Claims experience, health status, and duration of coverage are not case characteristics §22:228.1
Rating Restrictions	Index rate for one class of business shall not exceed the index rate for any other class of business by more than 20%; for a class of business, the premium rates charged small employers with similar case characteristics shall not vary from the index rate by more than 25% §7(1)(2)	Index rate for one class of business shall not exceed the index rate for any other class of business by more than 20% For a class of business, the premium rates charged small employers with similar case characteristics shall not vary from the index rate by more than 25%. §22:228.2
Transitional Period	3 years §7(6)	3 years (until 1/1/94) §22:228.1
Renewal Rating	Trend plus 15% plus changes in case characteristics §7(3)(b)	Trend plus 15% plus changes in case characteristics. §22.228.2
Renewability	Guaranteed renewable except "for cause" §5(c)	Guaranteed renewable except "for cause." §22:228.3
Whole Groups	Prohibits carrier from excluding any employer or dependent on the basis of an actual or expected health condition §5(c)6(c)	
Continuity of Coverage	Preexisting condition limitations of 12 months and waiting periods not to exceed one year; waiting periods may be waived if individual was covered by a group policy prior to the effective date of coverage with no gap in coverage §5(a)(b)	
Reinsurance Type	Prospective/with an opt-out §11(a)	
Reinsurance Price	To be established by the reinsurance board §13(g)6	
Cost Sharing	$10,000 plus 10% of the next $50,000; maximum in one calendar year shall not exceed 20% of total premiums §11(h)6(j)	
Assessments	Not to exceed 5% of small employer plan premiums; second tier not to exceed 1% of total premium upon which assessment is based §11(k)2(c)	
Other	Must reinsure the entire group; all carriers, whether reinsuring or not, subject to second tier assessment §11(k)2(b)	
Effective Date	July 1, 1992	September 30, 1992

	MAINE	MARYLAND
Availability	Guaranteed issue (1992 HP 507) §2808-B 4(A)	Guaranteed issue §704(A)
Group Size	1-24 §2808-B 1(D)	2-50 (3-50 until 1/1/95 if carrier does not impose pre-existing conditions.) §698(P)
Individual Policies	All policies, plans, contracts and certificates issued are subject to this section. §2808-B(7)	Could apply in the future as well as to larger groups
Case Characteristics	A carrier may not vary the premium rate due to the health status, claims experience or policy duration of the eligible group; age, gender, industry, and geography within the bands; family status, smoking status, participation in wellness programs, and group size may be used outside rate bands §2808-B 2(B)	Carriers may only adjust the community rates for age and geography. Geography is based on the Baltimore metropolitan area; the DC metropolitan area, Western Maryland and Eastern and Southern Maryland §702(A)
Rating Restrictions	Premium rates for age, gender, industry, and geographic area may not vary by +/- 50% of the community rate until 7/14/94, +/- 33% of the community rate until 7/14/95, +/- 20% of the community rate until 7/14/96, +/- 10% of the community rate until 7/14/97, and 0% of the community rate by 7/14/97, restrictions are repealed 7/14/94 unless continued or modified §2808 B 2(D)	Carriers may charge 50% above or below the community rate between 7/1/94 and 6/30/95; 40% between 7/1/95 and 6/30/96, 33% between 7/1/96 and 6/30/97, and 16% after 7/1/97. §702(B)
Transitional Period	None	No provision
Renewal Rating	No provision	No provision.
Renewability	Guaranteed renewable except "for cause" §2808-B (4)B	Guaranteed renewable except "for cause" §705
Whole Groups	(1990 - applies to all groups) Prohibits carriers from excluding any person from group; all new eligible employees must be added; may reject group until guaranteed issue is effective §2829-B	Carriers are required to take the whole group. §704(B)
Continuity of Coverage	(1990 - applies to all groups) Requires continuity for any person eligible for coverage in prior 3 months in a group replacement situation or for person moving from individual to group or group-to-group coverage; limit on 10% on premium rate increases for preexisting conditions during first 12 months of employment; preexisting condition limitations of 6 months for individual policies, except up to 24 months for any condition that as of the effective date of coverage requires ongoing medical treatment (H 1641) §2849-2(B)B,6 §2850(2)	Until 12/31/94, preexisting condition limitation of 6 months; credit given if previous coverage was continuous 60 days prior to the new coverage Late enrollees may be subject to 12 month limitation. Waiting periods not to exceed 30 days if no pre-ex used §701
Reinsurance Type	Requires the Bureau of Insurance to report to the Banking and Insurance Committee on or before January 1, 1993, on reinsurance models with opt-out §5	Prospective/with an opt-out. §706
Reinsurance Price	No provision	Whole Group: 150% Individual: 500% §709(B)
Cost Sharing	No provision	$5,000 plus 10% of the next $50,000 of incurred claims during a calendar year; liability maximum of $10,00 in any one calendar year with respect to any reinsured individual §709(A)5
Assessments	No provision	Formula to be set by Board, but must be 50% - 150% of carrier's proportional share of all reinsuring carriers' small employer premiums; maximum amount shall be 5% of total premiums earned in previous year from small employer plans §709(D)
Other	Marketing standards; superintendent will develop standardized plans §2808-B (6)	Loss ratio 75% and expense ratio 20% or commissioner may require the insurer or HMO to file new rates. §712
Effective Date	July 15, 1993 (for rating and guaranteed issue)	July 1, 1993

	MASSACHUSETTS	MINNESOTA
Availability	Guaranteed issue; however, until December 31, 1994, a carrier can limit the guaranteed issue requirement to 90 consecutive days a year; certain association groups are exempted from all but the reinsurance portion of the bill (1991 HB 6307) §2(b), 4(e)1	Guaranteed issue of all products sold in small employer market (1992 HB 2800, SB 2603) §3 subd. 1, 4 subd. 1
Group Size	1-25 §1	2-29 §subd. 26
Individual Policies	Does not apply to individual policies §2(e)	All provisions except guaranteed issue apply to individual policies §12 subd. 1,2,6 subd. 27(i)(ii)
Case Characteristics	Age, sex, rate basis type, industry, number of eligible persons, and participation rate of a group §1	Relevant characteristics of small employer as determined by carrier in determination of premiums; claims experience, health status, industry, duration of coverage, and gender are not case characteristics §2 subd. 6, 3 subd. 4
Rating Restrictions	Premium rates are limited to a 2-1 rate band; however, the following adjustments are permitted outside that band: benefit level, geography +/- 20%, group size +/- 5%, wellness discount -5%, phase out adjustment for experience and duration rating on existing business to reach +/- 15% by 12/31/94, age +/- 33% until 12/31/93 §3(e)1, 3(e)3(4), 3(e)7	Rates must not vary by more than +/- 25% of the index rate for same or similar coverage; inside the rating band, variations can be based only on health status (includes refraining from tobacco use or other actuarially valid lifestyle factors), claims experience, industry, and length of time employer has been covered, adjustments outside the band: age +/- 50%, geography +/- 20%, rate cells are permitted based on number of adults and children covered under the policy §8 subd. 2,3,4,5,6
Transitional Period	Phase out of rating restrictions §3(e)8	None
Renewal Rating	Trend plus 10% plus changes in case characteristics §3(b)	No provision
Renewability	Guaranteed renewable except "for cause" §4(b)(1)(2)	Guaranteed renewable except "for cause" §3 subd. 5
Whole Groups	Prohibits policies from excluding eligible employees or eligible dependents on the basis of an actual or expected health condition of such person §5(a)	Application must include all eligible employees §4 subd. 1
Continuity of Coverage	Preexisting condition exclusion of 6 months; credit shall be given if a person was covered under qualifying previous coverage if previous coverage was continuous 30 days prior to the new coverage and if previous coverage was reasonably actuarially equivalent to new coverage §5(b)	Preexisting condition exclusion of 12 months; requires credit for time covered under qualifying prior coverage; permits 18 month preexisting condition limitation for late entrants §3 subd 4
Reinsurance Type	Prospective/mandatory for commercials §8	prospective/with an opt-out §13, 18(1)
Reinsurance Price	Whole Groups: 150% Individuals 500% §8(1)(2)	Whole Groups: 150% Individuals: 500% §21(1)
Cost Sharing	$5,000 §8	$5,000, plus 10% of the next $50,000 §20(1)
Assessments	5% of small employer premiums; if inadequate, other funding sources will be recommended §8(7)	Initially, $100; in addition, not to exceed 4% of the member's small group market premium (if it is determined that premium charges are insufficient to cover the losses) §22(2)(3)
Other		Loss ratios: initially 65% for individual policies, 75% for group policies; increases by 1% per year to 70% and 80%, respectively §8(1)
Effective Date	April 1, 1992	Most provisions July 1, 1993

	MISSOURI	MONTANA
Availability	Guaranteed issue (1992 SB 796) §6	Guaranteed issue §29 (1993 SB 285)
Group Size	3-25 §1(28)	3-25 §24(25)
Individual Policies	Generally applies to individual policies sold to small employers Sections 1-12 shall not apply to any plan when employees pay the total cost of the plan. §2(1)(2)(3),3	Individual policies sold to small employers meeting certain requirements are subject to this Act. §25
Case Characteristics	Relevant demographics of small employer as considered by carrier in determination of premiums; claims experience, health status, and duration of coverage are not case characteristics. §1(9), 4(10)	Relevant characteristics of small employer as determined by carrier in determination of premiums; claims experience, health status, and duration of coverage are not case characteristics. §24(3)
Rating Restrictions	Index rate for one class of business shall not exceed the index rate for any other class of business by more than 20%; for a class of business, the premium rates charged small employers with similar case characteristics shall not vary from the index rate by more than 25% §4(1)(2)	Index rate for one class of business shall not exceed the index rate for any other class of business by more than 20%, for a class of business, the premium rates charged small employers with similar case characteristics shall not vary from the index rate by more than 25%. If the MT health care authority certifies to the commissioner that the cost containment goal is met before 1/1/99, the premium rates charged to small employers with similar case characteristics for the same or similar coverage may not vary from the index rate by more than 20%. §27
Transitional Period	3 years §4(3)b	The commissioner shall adopt rules for a period of transition to comply with this section. §26(3)
Renewal Rating	Trend plus 15% plus changes in case characteristics §4(3)b	Trend plus 15% plus changes in case characteristics. §27c
Renewability	Guaranteed renewable except "for cause." §5	Guaranteed renewable except "for cause" §28
Whole Groups	Insurer must cover the whole group §6(5)a	Must cover whole group §29
Continuity of Coverage	Preexisting condition limitation of 12 months; credit shall be given if a person was covered under qualifying previous coverage if previous coverage was continuous 30 days prior to the new coverage, exclusive of applicable waiting periods. §6(2)1(2)	Preexisting condition exclusion of 12 months; waiting periods may be waived if individual was covered by a group policy prior to the effective date of coverage if previous coverage was continuous for 30 days prior to new coverage; permits 18 month preexisting condition limitation for late entrants. §29
Reinsurance Type	Prospective/mandatory with an opt-out after three years §7(1)	Prospective §30
Reinsurance Price	Whole Group: 150% §7(9)2	Whole Groups: 150% Individual: 500% §30
Cost Sharing	$5,000 plus 10% of the remaining incurred claims; maximum limit of $25,000 §7(8)3	$5,000, plus 20% of the next $100,000, with a maximum limit of $25,000 per year, per individual. §30
Assessments	Formula to be set by Board, but must be 50%-150% of carrier's proportional share of all reinsuring carriers' small employer premiums, maximum amount shall be 5% of total premiums earned in previous year from small employer plans. §11	The board shall determine §30
Other		Loss ratios: initially 65% for individual policies, 75% for group policies; increases by 1% per year to 70% and 80%, respectively §8(1)
Effective Date	Guaranteed issue and continuity of coverage provision effective July 1, 1994, all other sections effective July 1, 1993.	January 1, 1994 §30-34 July 1, 1993

	NEBRASKA	NEW HAMPSHIRE
Availability		No provision (1992 HB 321)
Group Size	1-25 LBN 419 §20	2-50 §420-F:1(XI)
Individual Policies	Does not apply to individual policies which are subject to policy form and premium rate approval. LBN 419 §22	Does not apply to individual health policies which are subject to policy form and premium rate approval §420-F:2(I),(II)
Case Characteristics	Relevant demographics of small employer as considered by carrier in determination of premiums. Claims experience, health status, and duration of coverage are not case characteristics. LBN 419 §13	Relevant demographics of small employer as considered by carrier in determination of premiums; claims experience, health status, and duration of coverage are not case characteristics §420-F:1(IV)
Rating Restrictions	Index rate for one class of business shall not exceed the index rate for any other class of business by more than 20%. For a class of business, the premium rates charged small employers with similar case characteristics shall not vary from the index rate by more than 25% LBN 419 §23	Rates charged during a rating period to small employers with similar case characteristics for same or similar coverage shall not vary from the index rate by more than 30% §420-F:3(I)a
Transitional Period	5 years LBN 419 §23	5 years §420-F:3(I)(3)c
Renewal Rating	Trend plus 15% plus changes in case characteristics. LBN 419 §24	Trend plus 15% plus changes in case characteristics §420-F:3(I)2
Renewability	Guaranteed renewable except "for cause." LBN 419 §24	Guaranteed renewable except "for cause" §420-F:4
Whole Groups		Insurer must cover the whole group §420-F:4
Continuity of Coverage		Preexisting condition limitations consistent with insurance department rules
Reinsurance Type		No provision
Reinsurance Price		No provision
Cost Sharing		No provision
Assessments		No provision
Other		
Effective Date	October 1, 1991	January 1, 1993

	NEW JERSEY	NEW MEXICO
Availability	Continuous open enrollment (guaranteed issue) §3b (S 371 1992)	
Group Size	2-49 §1	1-25 SBN 504 §3.K
Individual Policies	Applies to all health benefit plans covering 2 or more eligible employees of one or more small employers §2	Does not apply to individual policies which are subject to policy form and premium rate approval. SBN 504 §4.B
Case Characteristics	Prohibits the use of age, sex, health status, residence or occupation with community rating. §1	Relevant demographics of small employer as considered by carrier in determination of premium. Claims experience, health status, and duration of coverage are not claims characteristics SBN 504 §3.D
Rating Restrictions	Rates may not exceed 4 times the base premium rate charged to the lowest-rated group Plans must be community rated by 1/1/97. 1/1/94 to 12/31/95, premium rates charged to highest rated group shall not be greater than 300% of rate charged to lowest rated group. 1/1/96 to 12/31/96 greater than 200%. §9	Index rate for one class of business shall not exceed the index rate for any other class of business by more than 20% For a class of business, the premium rates charged small employers with similar case characteristics shall not vary from the index rate by more than 25%. SBN 504 §5.A(1) & (2)
Transitional Period	Policies whose term extends beyond 12/31/93 or contracted on or after 1/1/94 subjected to the act. §9(h)(i)	5 years SBN 504 §5.A(4)
Renewal Rating	Beginning 1/1/95 may make informational filing with commissioner of increase or decrease provided the loss ratio not be less than 75% §9g	Trend plus 15% plus changes in case characteristics SBN 504 §5.A(3)
Renewability	Guaranteed renewable except "for cause" §7	Guaranteed renewable except "for cause " SBN 504 §6.A
Whole Groups	Must offer coverage to all employees and their dependents. Cannot exclude based on actual or expected health condition. §2	
Continuity of Coverage	Generally no preexisting condition limitation. Prex may apply to a group of 2-5 if the period is 180 days forward and 6 months back, however, if 10 or more late enrollees request coverage prex does not apply. Credit shall be given if a person was covered under qualifying previous coverage if previous coverage was continuous 30 days prior to the new coverage, exclusive of applicable waiting periods §6	
Reinsurance Type	Prospective §12	
Reinsurance Price	Whole Group 150% Individual: 500% §20	
Cost Sharing	Receive reimbursement in accordance with standards developed by board §19a	
Assessments	Apportioned among all reinsuring members in proportion to their respective shares of the premiums earned from small group plans. Additional assessments of all members not to exceed 1% of premiums. §21c	
Other	No prex permitted -- see continuity of coverage. Some carriers paying 2nd tier assessments will receive a credit. §21c	
Effective Date	November 30, 1992	July 1, 1991

	NEW YORK	NORTH CAROLINA
Availability	Continuous open enrollment (guaranteed issue) (1992 A 12350-A) §3231	Guaranteed issue §143-629 (1993 HB 729, Chapter 529)
Group Size	3-50 for open enrollment §3231	2-49 §58-50-110(22)
Individual Policies	Must be community rated and must be offered through open enrollment §3231	Applies to individual health policies §143-623
Case Characteristics	Prohibits the use of age, sex, health status, or occupations; geography is permitted on a county-wide (or larger) basis; Since not prohibited, presumably group size, participation, wellness, and other case characteristics are permitted §3231(a,b)	Adjusted community rating methodology allowing the premium to vary on the basis of the eligible employee's or dependent's age, gender, number of family members covered or geographic area. Rating factors related to age, gender, number of family members covered or geographic location may be developed by each carrier to reflect carrier's experience. No age brackets of less than 5 yrs. May not apply different geographic rating factors to the rates of small employers located within the same county. §58-50-130
Rating Restrictions	No statutory restrictions on permitted case characteristics, but Department has rate approval authority for initial rates §3231(c)(e)	May not modify the rate for a small employer for 12 months from the initial issue date or renewal date, unless the composition of the group changed by 20% or more or benefits are changed. Community rating index line adjusted pro rata for a period of 2 yrs. beginning 1/1/95. Carriers participating in an Alliance may apply a different community rate. On 1/1/95 rates charged employers with similar case characteristics for the similar coverage shall not vary from the adjusted community rate by more than 20%. On 1/1/96 rates shall not vary by more than 10%. On 1/1/97 all small employer benefit plans issued before 1/1/97 will have rates based on the same adjusted community rating standard applied to new business. §58-50-130(b)
Transitional Period	The one-year delay in effective date is viewed as the transition period	5 years §58-50-130(b)7
Renewal Rating	Prior rating approval; beginning April 1, 1994, rates shall be deemed approved if policy has an anticipated loss ratio of not less than 75% §3231(e), 3231(2)a	Trend plus 15% plus changes in case characteristics §58-50-130(b)3(b)
Renewability	Coverage may not be terminated due to claims experience §3231	Guaranteed renewable except "for cause" §58-50-130a(3)
Whole Groups	Carriers must offer coverage to all employees and their dependents §3231	Must cover the whole group. §58-50-125
Continuity of Coverage	Plans must credit the time a person was covered under previous health insurance plan or benefit arrangement if the previous coverage was continuous to a date not more than 60 days prior to the effective date of new coverage §3232(e), 4318(a)	Preexisting condition limitation of 12 months; credit shall be given if a person was covered under qualifying previous coverage if previous coverage was continuous 60 days prior to the new coverage, exclusive of applicable waiting periods §58-50-130
Reinsurance Type	Demographic and large claims pooling mechanisms. §3233(c)	Prospective/with an opt-out §58-50-150
Reinsurance Price	No provision	Whole Group: 150% Individual: 500% §58-50-150(g)2(g)
Cost Sharing	No provision	$5,000 plus 10% of the next $50,000 §58-50-150(g)2(c)
Assessments	No provision	First 3 years: 50% - 150% of amount it would have been had assessments been based on proportional relationship of small carrier's total premiums; not to exceed 4% §58-50-150(i)i
Other	1 and 2 live employers must be classified in either the individuals or small groups rating category by the insurer §3231(b)	Sets up non-exclusive Health Plan Purchasing Alliances. §143-628
Effective Date	Community rating and open enrollment take effect April 1, 1993; continuity of coverage takes effect January 1, 1993 §21	The provisions of HB 729 became effective upon ratification (July 24, 1993) unless otherwise specified in the act.

	NORTH DAKOTA	OHIO
Availability	Guaranteed issue (group size 3-25) §6 (1993 HB 1504) *waiting for final bill	Modified open enrollment. Carriers must open enroll 1/2 of 1% of total block of business.
Group Size	1-25 §1(25)	2-50 §3923.58
Individual Policies	Individual policies sold to small employers meeting certain requirements are subject to this Act. §2	Subject to law if any portion of the premium or benefits is paid by the employer, or any individual is reimbursed for any portion of the premium. Subject to open enrollment. §3924.02(A)
Case Characteristics	Age, gender, industry, geographic area, family composition and group size. Claim experience, health status and duration of coverage are not characteristics §1(7), §4	Geography, age, sex and industry classification. Does not include claims experience, health status or duration of coverage. §3924.01(E)
Rating Restrictions	Index rate for one class of business shall not exceed the index rate for any other class of business by more than 20%; for a class of business, premium rates charged small employers with similar case characteristics shall not vary from the index rate by more than 25% §4	Premium rates for small employer plans with similar case characteristics may not vary from the midpoint rate for those small employers by more than 35% of that midpoint rate. §3024.04
Transitional Period		Rates that exceed rate band may not use experience
Renewal Rating	Trend plus 15% plus changes to case characteristics §4(2)	Trend plus 15% changes in case characteristics §3924.04(C)
Renewability	Guaranteed renewable except "for cause" §5	Guaranteed renewable except "for cause." 3924.03(C)
Whole Groups	Must cover whole group. §6(3)	Cannot exclude eligible employees or dependents on the basis of an actual or expected health condition. §3924.03(F)
Continuity of Coverage	Preexisting condition limitation of 12 months relating to conditions 6 months before coverage. Waiting periods waived for the time an individual was previously covered if the coverage was continuous 30 days prior to the effective date of new coverage. Does not preclude application of a waiting period for all new enrollees §6(3)	Preexisting condition limitation of 12 months relating to conditions 6 months before coverage. Waiting periods not be more than 90 days. Credit time a person covered under a previous health plan for 30 days prior to the effective date of the new coverage, exclusive of any applicable waiting period. Late enrollees may be excluded up to 24 mos. §3924.03
Reinsurance Type	Prospective §7	Prospective §3924.07
Reinsurance Price	$5000, plus 10% of the next $50,000 not to exceed $10,000 in a year per individual. §7(8)	Whole Group: 150% Individual: 500% §3924.12(A)
Cost Sharing	Whole groups: 150% Individuals: 500% §7(8)	None
Assessments	Formula set by Board, but must be 50%-150% of carrier's proportional share of premiums; maximum amount 5% of total premiums earned in previous year. §7(11)	Apportioned among all members in proportion to their respective shares of the total premiums earned from small group plans. Assessment will not exceed 1%. §3924.13(B)
Other		
Effective Date		January 14, 1993

	OREGON	PENNSYLVANIA
Availability	Guaranteed issue (1991 SB 1076) §6(4)	
Group Size	3-25 §3(25)	Not defined
Individual Policies	Applies to individual policies providing health benefits covering one or more employees of a small employer; provisions of OR 742.005 do not apply to individual policies subject to this law §5(1)(2)	Silent
Case Characteristics	Geography and differences in family size and composition §7(6)b	Silent
Rating Restrictions	Premium rates may not vary from the geographic average rate by more than 33% except that the premium rate may be adjusted to reflect the provision of additional benefits not covered by the basic health care plan and differences in family size and composition §7(6)b	The Department's policy prohibiting exclusion of individual at policy inception or for new entrants due to medical conditions in small group health policies was affirmed. Insurance Federation of Pennsylvania, Inc. v. Foster. Index rate for one class of business shall not exceed the index rate for any other class of business by more than 20%; for a class of business, the premium rates charged small employers with similar case characteristics shall not vary from the index rate by more than 25% §27-49-6(1,2)
Transitional Period	Effective on the date the reinsurance pool becomes operational §7(10)a	None
Renewal Rating	Trend plus 15% plus adjustments to reflect provision of benefits not required to be covered by basic health care plan §7(6)c(B)	Silent
Renewability	Guaranteed renewable except "for-cause" §7(4)	Silent
Whole Groups	Prohibits carriers from excluding individuals on the basis of actual or expected health condition §7(3)	
Continuity of Coverage	Preexisting condition limitation of 6 months, credit shall be given if the person was covered under a previous group or individual plan if the previous coverage was continuous 30 days prior to the new coverage, exclusive of applicable waiting periods §7(1)(2)	
Reinsurance Type	Prospective/with an opt-out §10,11	
Reinsurance Price	Existing business: none Whole Group: 150% Individual: 300% §11(8)a,b	
Cost Sharing	$5,000 plus 15% of the next $100,000 §11(7)d	
Assessments	Maximum assessment is 4% of small employer premium plus 1% of members' total health insurance premiums §11(12)a	
Other		
Effective Date	On or after the date the Oregon Small Employer Reinsurance Pool becomes operational	February 27, 1991

	RHODE ISLAND	SOUTH CAROLINA
Availability	Guaranteed issue (groups of 3-25) (1992 H 9011 Sub. A)	No provision
Group Size	1-50 §27-49-4(AA)	1-25 §38-71-920(1)
Individual Policies	Generally applies to individual policies sold to small employers §27-49-4	Does not apply to individual health policies subject to policy form and premium rate approval §38-71-930(A,B)
Case Characteristics	Relevant demographics of small employer as considered by carrier in determination of premiums; claims experience, health status, and duration of coverage are not case characteristics §27-49-3(F)	Relevant demographics of small employer as considered by carrier in determination of premiums; claims experience, health status, and duration of coverage are not case characteristics §38-71-920(5)
Rating Restrictions	Index rate for one class of business shall not exceed the index rate for any other class of business by more than 20%; for a class of business, the premium rates charged small employers with similar case characteristics shall not vary from the index rate by more than 25% §27-49-6(1,2)	Index rate for one class of business shall not exceed the index rate for any other class of business by more than 20%; for a class of business, the premium rates charged small employers with similar case characteristics shall not vary from the index rate by more than 25% §38-71-940
Transitional Period	3 years §27-49-6(7)	5 years §38-71-940(A)4
Renewal Rating	Trend plus 15% plus changes in case characteristics §27-49-6(3)b	Trend plus 15% plus changes in case characteristics §38-71-940(A)3(B)
Renewability	Guaranteed renewable except "for cause" §27-49-7	Guaranteed renewable except "for cause" §38-71-950
Whole Groups	Carriers are required to take the whole group §27-49-8c(5a)	Prohibits carriers from excluding any individual from the group; however, in groups of 10 or less, evidence of individual insurability may be required §38-71-730(3)
Continuity of Coverage	Plans must credit the time a person was covered by qualified previous coverage provided the coverage was continuous; qualified previous coverage is defined as Medicare, Medicaid, employer-based health insurance, or individual insurance providing similar or exceeding benefits §27-49-8(c)	Preexisting condition limitations of 12 months; credit shall be given for time served under a prior plan if the coverage is selected when the person first becomes eligible and the coverage is continuous; service waiting periods are not considered to interrupt continuous service §38-71-730(4)
Reinsurance Type	Prospective with an opt out §27-49-11	No provision
Reinsurance Price	Whole Group: 150% Individual: 500% §27-49-11(9)5(2)	No provision
Cost Sharing	First $5,000 of reinsured claims §27-49-11(9)(4A)	No provision
Assessments	5% of total premiums earned in small employer market §27-49-11(L)(3c)	No provision
Other	Standard and economy health benefit plans are included within the law and are based on Rhode Island's low-cost limited mandated benefit law. Copayment, deductibles, and coinsurance are outlined. §27-49-12	
Effective Date	July 21, 1992	January 1, 1992

	SOUTH DAKOTA	TENNESSEE
Availability		Guaranteed issue (1992 SB 2578) §8(E)
Group Size	1-25 SBN 229, §1	3-25 §3(24)
Individual Policies	Does not apply to individual health policies subject to policy form and premium rate approval. SBN 229, §2	Generally applies to individual policies sold to small employers. Provisions of TCA, Title 56, Chapter 5, Part 3 do not apply to individual policies subject to this law. §6(c,b)
Case Characteristics	Relevent demographics of small employer as considered by carrier in determination of premiums. Claims experience, health status, and duration of coverage are not case characteristics. SBN 229, §1	Relevant demographics of small employer as considered by carrier in determination of premiums; claims experience, health status, and duration of coverage are not case characteristics §3(6)
Rating Restrictions	Index rate for one class of business shall not exceed the index rate for any other class of business by more than 20%. For a class of business, the premium rates charged small employers with similar case characteristics shall not vary from the index rate by more than 25% SBN 229, §3.	Index rate for one class of business shall not exceed the index rate for any other class of business by more than 25%, for a class of business, the premium rates charged small employers with similar case characteristics shall not vary from the index rate by more than 35% §9(b)
Transitional Period	5 years SBN 229, §3	3 years §9(b)7
Renewal Rating	Trend plus 15% plus changes in case characteristics. SBN 229, §3	Trend plus 15% plus change in case characteristics 9(b)3(B)
Renewability	Guaranteed renewable except "for cause." SBN 229, §4	Guaranteed renewable except "for cause" §9(3)
Whole Groups		No provision
Continuity of Coverage		Preexisting condition limitation of 12 months; plans shall credit the time person was covered under a previous group health benefit plan if previous coverage was continuous 30 days prior to the new coverage §9(1,2)
Reinsurance Type		Prospective/with an opt-out §13(e)
Reinsurance Price		Whole Group: 150% Individual: 500% §13(g)2(c)
Cost Sharing		$5,000 plus 10% of the next $50,000 §13(g)2(c)
Assessments		Capped at 5% of small employer premiums; formula to be set by board but must be 50% to 150% of carrier's proportional share of all reinsuring carriers' small employer premiums §13(h)(2,4)
Other		Guaranteed issue requirement suspended if assessment cap is reached §13(h)4
Effective Date	July 1, 1992	July 1, 1992; January 1, 1993 for preexisting condition and guaranteed renewable provisions

	TEXAS	VERMONT
Availability	Guaranteed issue (9/1/95) §26.21 HB 2055 1993	Guaranteed issue §4080a(4)d(1)
Group Size	3-50 §26 01	1-49 §4080a(1)
Individual Policies	Generally applies to individual policies sold to small employers. §26.06	May not offer a health benefit plan or insurance policy to individual employees or members of a small group as a means of circumventing the act §4080a(4)h(3)m
Case Characteristics	Geography, age, gender, industry classification, number of employee and others. Claims experience, health status, medical history or pregnancy are not case characteristics. §26.01	The following risk classification factors are prohibited: demographic rating, including age and gender, geographic area rating, industry rating, medical underwriting and screening, experience rating, tier rating, or durational rating; Commissioner may by rule permit carriers to use one or more risk classifications §4080a(h)1
Rating Restrictions	Index rates shall not exceed another class by more than 20%; or within a class by more than 25%. (NAIC rate bands) §26.32	Premiums may not deviate by more than +/- 20% of the community rate filed by the small employer carrier §4080a(h)2
Transitional Period	May exceed ranges until 9/1/95.	In force business will not be subject to the provisions of the Act until the later of the date of renewal, anniversary, or July 1, 1992 §5112(6)b
Renewal Rating	Trend plus 15%.	No provision
Renewability	Guaranteed renewable except "for cause." §26.23	Must guarantee rates for six months; must guarantee acceptance §4080a(k)
Whole Groups		Carrier must take entire group §4080a(a)4(d)
Continuity of Coverage	Pre-ex may be excluded for 12 months if treatment sought within 6 months prior to coverage. Does not apply if individual was continuously covered for 12 months and only had a gap of 60 days Credit given for any day coverage in effect during preceding 12 months. May establish waiting period up to 90 days.	Preexisting condition limitation of 12 months; limitation shall be waived if there is evidence of substantially equivalent continuous coverage during previous 9 months §4080a(g)
Reinsurance Type	Prospective with opt out §26.51-62	Prospective/mandatory for commercials, participants must guarantee solvency w/out limitation on a pro-rata basis §4080a(o)
Reinsurance Price	Whole Group: 150% Individual: 500% §26.59	No provision
Cost Sharing	$5,000 plus 10% of the next $50,000 with a $10,000 cap per individual per year.	No provision
Assessments	5% cap. Must be 50%-150% of carrier's proportional share of all reinsuring carriers' small employer premiums. §26.60	No provision
Other	Guaranteed issue is suspended if assessment cap is reached. Provides three mandated benefit packages which must be offered by 1/1/94, primary and preventive, in-hospital and standard. §26.42	Participation requirement = 75% of employees; most provisions do not apply to registered carriers who on 1/1/91 and thereafter have written or collected less than $100,000 in annual gross premiums for group health benefit plans §4080a(1)h(3)l
Effective Date	September 1, 1993 (offering of the mandated plans does not begin until 1/1/94 and guarantee issue isn't until 9/1/95).	July 1, 1992

	VIRGINIA	WASHINGTON
Availability	Guaranteed issue.* §38.2-3431(D) (*1993 HB 2353 amendments)	(1993 SB 5304)
Group Size	2-25 for guaranteed issue, 2-50 for other reforms §38.2-3431(B)	Covers everyone. Employer and individual mandate. Requires residents to purchase a uniform benefit package from a certified health plan by 7/1/99.
Individual Policies	Subject if any portion of the premiums or benefits is paid by the employer, if the employee is reimbursed or if the plan is treated as part of a program for the purpose of the US Internal Revenue Code §38.2-3431(A)	
Case Characteristics	Based on a community rate subject to demographic rating including age, gender and geography. May not use claim experience, health status or duration. *	Family size and geography.
Rating Restrictions	Premium rates charged by a small employer may deviate above or below the community rate by no more than 20% for claim experience, health status and duration only during a rating period for such groups within similar demographics for the same or similar coverage. Rating factors, including case characteristics will be applied consistently with respect to all primary small employers in similar demographics. Adjustments in rates for claims experience, health status and duration from issue may not be applied individually.*	Community rating. Must provide benefits of the uniform privilege on a pre-paid per capital community rated premium not to exceed the maximum premium established by the commission and provide benefits through managed care.
Transitional Period	No provision	
Renewal Rating	No provision	
Renewability	Guaranteed renewable except "for cause" §38.2-3432(B)	
Whole Groups	Prohibits carriers from excluding individuals because of health status §38.2-3432(1)(3)	
Continuity of Coverage	Preexisting condition limitation of 12 months; time shall be credited to a person covered under previous individual or group coverage in the small employer market of equal or greater value if coverage was continuous 30 days prior to new coverage, exclusive of applicable waiting periods. Late enrollee may be excluded for 18 months §38.2-3432(1)(3)	After 1/1/94, every individual and group disability insurer HMO and health service contract is to waive any pre-existing condition, exclusion or limitation in 3 month period preceding effective date of coverage. If person met a 12 month waiting period in the preceding policy, insurer will waive pre-existing condition limitation.
Reinsurance Type	No provision	
Reinsurance Price	No provision	
Cost Sharing	No provision	
Assessments	No provision	
Other		
Effective Date	April 1, 1994	Effective 7/1/93 except § 234-257 on 7/1/95 and §301 on 1/1/96

	WYOMING
Availability	Guaranteed issue §26-19-306
Group Size	2-25 §26-19-302(xxii)
Individual Policies	Does not apply to individual policies which are subject to approval for policy form. §26-19-303
Case Characteristics	Relevant demographics of small employer as considered by carrier in determination of premiums; claims experience, health status, and duration of coverage are not case characteristics §26-19-302(vi)
Rating Restrictions	Index rate for one class of business shall not exceed the index rate for any other class of business by more than 20%; for a class of business, the premium rates charged small employers with similar case characteristics shall not vary from the index rate by more than 25% §26-19-304
Transitional Period	3 years §26-19-304(a)viii
Renewal Rating	Trend plus 15% plus changes in case characteristics §26-19-304(a)iii(B)
Renewability	Guaranteed renewable except "for cause" §26-19-305
Whole Groups	Insurers are required to offer coverage to the entire group §26-19-306(c)vi
Continuity of Coverage	Preexisting condition limitation of 12 months; credit shall be given for time person was previously covered if previous coverage was continuous 30 days prior to new coverage, exclusive of applicable waiting periods, or for a person who become unemployed and are provided coverage if the person obtains employment and coverage within 60 days §26-19-306(c)i
Reinsurance Type	Prospective/mandatory §26-19-307
Reinsurance Price	Whole Group: 150% Individual: 500% §26-19-307(k)i,ii
Cost Sharing	$5,000 §26-19-307(l)x,v
Assessments	Not to exceed 5% of the total small group premiums §26-19-307(n)A
Other	
Effective Date	No earlier than March 31, 1993

COMPREHENSIVE SMALL EMPLOYER PACKAGES

	HIAA	NAIC
Availability	Guaranteed issue	Guaranteed issue (groups of 3-25)
Group Size	3-25	1-25
Individual Policies	Individual policies sold to small employer subject to Act; however, if state has effective rate regulation, the rating requirements do not apply	Does apply to individual policies; although drafting note says that states may wish to consider exempting individual health policies from the rating provisions
Case Characteristics	Geography, age, sex, size of employer, and other objective criteria, but does not include claims experience, health status, or duration of coverage	Small employer carriers may not use case characteristics other than age, gender, industry, geographic area, family composition, and group size without prior approval of Commissioner
Rating Restrictions	Premium rates for small employer plans with similar case characteristics may not vary from the midpoint rate for those small employers by more than 35% of that midpoint rate	Index rate for one class of business may not exceed the index rate for any other class of business by more than 20%; for a class of business, the premium rates charged small employers with similar case characteristics shall not vary from the index rate by more than 25%
Transitional Period	3 years	3 years
Renewal Rating	Trend plus 15% plus changes in case characteristics	Trend plus 15% plus changes in case characteristics
Renewability	Guaranteed renewable except "for cause"	Guaranteed renewable except "for cause"
Whole Groups	Carriers must take the entire group	Carriers must take the entire group
Continuity of Coverage	Plans must credit the time a person was covered under a previous employer-based plan if coverage was continuous.	Plans must credit the time a person was covered by qualified previous coverage provided the coverage was continuous; qualified previous coverage is defined as Medicare, Medicaid, employer-based health insurance, or individual insurance providing similar or exceeding benefits
Reinsurance Type	Prospective/mandatory	Individual states will determine whether to make participation in reinsurance mandatory or voluntary
Reinsurance Price	Whole Group: 150% Individual: 500%	Whole Group: 150% Individual: 500%
Cost Sharing	None	First $5000 of reinsured claims plus 10% of next $50,000
Assessments	4% of the premium of small employer market net of reinsurance premiums paid	5% of the premium of the small employer market
Other	Carriers may reinsure existing business and new adds	
Effective Date		

HIAA

Health Insurance Association of America

Actuarial Memorandum
Premiums in Regional Health Alliances
Under the Clinton Administration's Proposed Health Security Act

P. Anthony Hammond, ASA, MAAA

This memorandum presents the assumptions and methods used to develop an average 1994 premium estimate for the Clinton Administration's standard benefit package. In calculating premium rates within Regional Health Alliances under the Health Security Act, I had to assume, as the Administration had assumed, that all coverage and administrative requirements under the Act were fully implemented on 1/1/94.[1]

In developing the premium, I used a standard actuarial approach, which included the following steps:

(1) Defining a database of claims appropriate for pricing the risks to be incurred and calculating the average expected (base) claims cost from this database;

(2) Making appropriate adjustments to the claims cost derived from the database in order to develop the net premium (before expenses, margins, etc.);

(3) Determining appropriate adjustments to the net premium (usually referred to as retention or loading and expressed as a percent of the gross premium, i.e., total premium after loading is added into the net premium);

(4) Combining steps (1) through (3) to determine the gross premium; and,

(5) Sensitivity testing the rating formula to look for any factor or assumption that could skew the actual results from the expected results.

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[1] There are several reasons why premiums developed in such a manner do not represent real premiums that anyone might actually pay to any health plan in 1994, even if the Health Security Act were enacted. For example, universal coverage may actually take years to implement. But, since the Administration's premium estimates assume that universal coverage is fully implemented in a mature market, I made the same assumption in producing my estimates so my figures could be compared to theirs.

These premium estimates should only be used for comparison with the premium estimates the Clinton Administration presented with the proposed Health Security Act or for comparison with other premium estimates developed specifically for the same purpose.

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Each of these five steps is summarized briefly in the next two pages and then in greater detail in the remainder of this memo.

First, I developed a base claims cost for a single person by asking several commercial carriers to estimate the 1994 expected claims cost for employer groups with the standard benefit package described in the 9/7/93 working-group draft of the Administration's reform proposal. I then averaged these carriers' estimates together with another estimate I derived from the Tillinghast Group Rating Manual. All the estimates were nationally representative, and I adjusted them for subsequent changes in the benefit package as well as other factors.

Using the March 1992 Current Population Survey's data on the distribution and average size of currently insured families, claim cost factors from the Tillinghast Group Rating Manual, and the base claims cost for a single person, I developed base claims costs for couples, single-parent families and two-parent families. I then adjusted these base claims costs for changes in the average claims cost that would result from moving to universal coverage, including a migration adjustment to reflect the uninsured becoming insured under the Act. For this adjustment I used nationally representative data from the 1987 National Medical Expenditure Survey (NMES). In short, I developed the base claims cost and adjusted for changes in the covered population. The method and assumptions are described in sections 1 & 2, below.

The second step (developing the net premium) is detailed in sections 3, 4, and 5. Changes in the base claims cost are made to reflect the average expected claims cost or net premium for the population actually eligible for regional alliances.

The third step (loading the net premium for expenses, taxes, and margins) is described in sections 6, 7 and 8. The first part of the loading factor is for surcharges and assessments added by the Health Security Act. Loading of current expenses and taxes is explained in section 7. Changes from the current expense loadings are addressed in section 8.

The fourth step, which combines the first three steps to determine the gross premium, is basically an algebraic formula:

$$\frac{\text{(Base claim cost) x (Adjustments)}}{\text{1-loading}} = \frac{\text{Net Premium}}{\text{1-loading}} = \text{Gross Premium.}$$

My objective was to develop a premium for the standard benefit package under the Health Security Act that was comparable to the

Administration's premium estimates, as found on page 112 of *Health Security: The President's Report to the American People.*

In Table 2, my premium estimates for the Health Security Act are compared to the Administration's premium estimates and to premiums developed by Hewitt Associates which were presented in Congressional testimony.

Once I calculated premium estimates for the Health Security Act, I tested them for sensitivity to changes in specific assumptions (the fifth step above). Through sensitivity testing, I was able to determine how sensitive the premium estimates were to changes in the assumptions and how conservative my estimates were. The results of the sensitivity testing are discussed below and compiled in Tables 3 and 4.

Table 3 shows the resulting percentage change in premium for various changes in the rating assumptions.

Table 4 shows changes in specific assumptions that would result in a 1 percent change in the premium. For example, if the savings from uncompensated care were 10 percent less than expected, premiums would be 1 percent higher. Likewise, if Medicaid morbidity were 11 percent higher, premiums would be 1 percent higher.

Table 5 shows how the premium estimates would vary by state. These premiums are only for the high cost-sharing plan, however, so they may not be appropriate for comparisons in states with a high HMO penetration (market share). Actuarial judgment should be exercised when using these estimates in states with large HMO population/penetration.

Components of the premium, and the assumptions used in developing the HIAA estimate, are described in some detail in the numbered sections following the tables.

Table 1

Premiums in Regional Health Alliances Under the Clinton Administration's Proposed Health Security Act

(National Average Premiums for High Cost–Sharing Plan)

Annual Premiums

Family Status	Clinton Administration	Hewitt Associates	HIAA
Single	$1,932	$2,440	$2,509
Couple	$3,865	$4,880	$5,419
Single–Parent Family	$3,893	$4,619	$4,270
Two–Parent Family	$4,360	$6,946	$7,278

Monthly Premiums

Family Status	Clinton Administration	Hewitt Associates	HIAA
Single	$161	$203	$209
Couple	$322	$407	$452
Single–Parent Family	$324	$385	$356
Two–Parent Family	$363	$579	$607

Sources: "Health Security: The President's Report to the American People," page 112 (Administration's estimates); Testimony before U.S. House Subcommittee on Health and the Environment of the Committee on Energy and Commerce, November 22, 1993 (Hewitt Associates' estimates); and HIAA

Table 2

Comparison of HIAA Premium Estimates for Health Security Act to Hewitt Associates and Clinton Administration Estimates

Single Person Premium

Assumptions	Single Person Premium	Compared to HIAA Estimate	Compared to Hewitt Associates	Compared to Administration
1. HIAA estimate for Health Security Act	$2,509	--	3%	30%
2. Hewitt Assoc. estimate for Health Security Act	$2,440	-3%	--	26%
3. Administration estimate for Health Security Act	$1,932	-23%	-21%	--

Two-parent Family Premium

Assumptions	Two-parent Family Premium	Compared to HIAA Estimate	Compared to Hewitt Associates	Compared to Administration
1. HIAA estimate for Health Security Act	$7,278	--	5%	67%
2. Hewitt Assoc. estimate for Health Security Act	$6,946	-5%	--	59%
3. Administration estimate for Health Security Act	$4,360	-40%	-37%	--

Sources: "Health Security: The President's Report to the American People," page 112 (Administration's estimates); Testimony before U.S. House Subcommittee on Health and the Environment of the Committee on Energy and Commerce, November 22, 1993 (Hewitt Associates' estimates); and HIAA

Table 3

Sensitivity Testing and Comparison of HSA Premium Estimates (Single Person Premium)

Assumptions	Single Person Premium	Compared to HIAA Estimate
1. HIAA estimate for Health Security Act	$2,509	0%
2. No change in distribution of policies by family status	$2,535	1%
3. Disregard Medicaid	$2,537	1%
4. Medicaid at 120% morbidity	$2,552	2%
5. Medicaid and uninsured at 120% morbidity (cost)	$2,632	5%
6. 25% fewer retirees (25% shifted to EEs @ EE cost)	$2,445	−3%
7. Lower retiree morbidity (50% of excess over EE)	$2,378	−5%
8. Lower retiree/indiv morbidity (50% less of excess)	$2,361	−6%
9. Lower retiree/indiv, higher Medicaid/unins (#5 & #8)	$2,484	−1%
10. Aggregate cost of migration reduced by 50%	$2,358	−6%
11. 1% higher claims	$2,533	1%
12. 5% higher claims	$2,630	5%
13. Lower, 7.5%, savings from uncompensated care	$2,582	3%
14. Lower, 5%, add−on for surcharges and assessments	$2,447	−2%
15. Lower, −0.9%, change in retention	$2,475	−1%
16. Higher, 1.2%, change in retention	$2,541	1%

Source: HIAA

Table 4

Changes in Assumptions for HSA Premium That Result in a 1% Change (Single Person Premium)

Assumptions	Single Person Premium	Compared to HIAA Estimate
1. HIAA estimate for Health Security Act	$2,509	0%
2. No change in distribution of policies by family status	$2,535	1%
3. Disregard Medicaid	$2,537	1%
9. Lower retiree/indiv, higher Medicaid/unins (#5 & #8)	$2,484	−1%
11. 1% higher claims	$2,533	1%
17. Medicaid at 111% morbidity	$2,532	1%
18. Medicaid and uninsured at 104% morbidity (cost)	$2,534	1%
19. 10% fewer retirees (10% shifted to EEs @ EE cost)	$2,483	−1%
20. Lower retiree morbidity (10% lower excess, 192%)	$2,483	−1%
21. Lower retiree/indiv morbidity (8% lower excess)	$2,485	−1%
22. Aggregate cost of migration reduced by 10%	$2,479	−1%
23. Savings from uncompensated care reduced by 10%	$2,534	1%
24. Additional 1% add−on for surcharges and assessments	$2,541	1%
25. Greater reduction in retention: 0.9% more	$2,481	−1%

Source: HIAA

Table 5

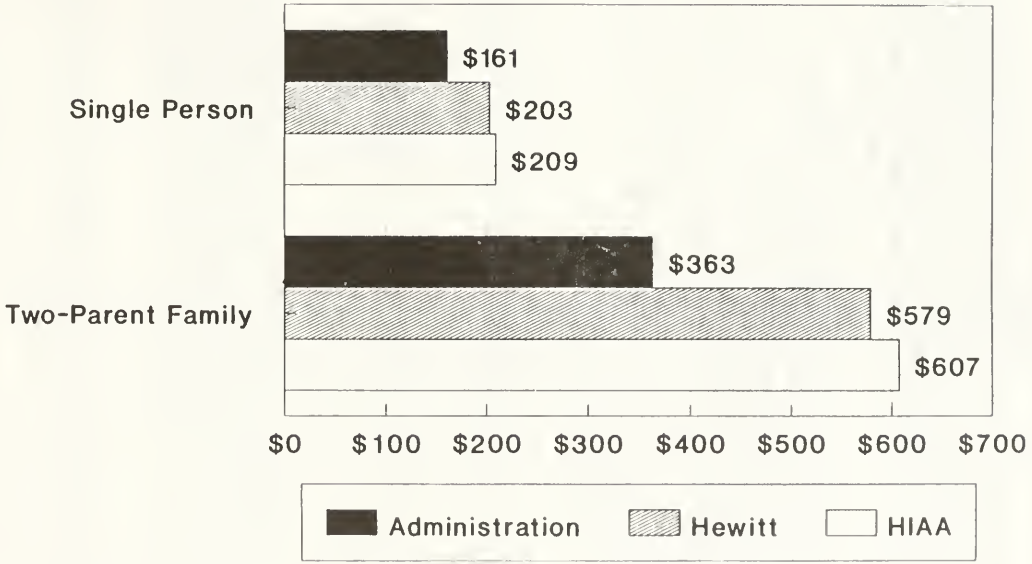
HIAA Estimate of Premium for Health Security Act by State *

STATE	GEOGRAPHIC FACTOR	SINGLE	COUPLE	SINGLE PARENT	TWO PARENT
ALABAMA	89%	$2,233	$4,823	$3,800	$6,477
ALASKA	120%	3,011	6,503	5,124	8,734
ARIZONA	96%	2,409	5,202	4,099	6,987
ARKANSAS	87%	2,183	4,715	3,715	6,332
CALIFORNIA *	145%	3,638	7,858	6,192	10,553
COLORADO	89%	2,233	4,823	3,800	6,477
CONNECTICUT	98%	2,459	5,311	4,185	7,132
DELAWARE	95%	2,384	5,148	4,057	6,914
DISTRICT OF COL	120%	3,011	6,503	5,124	8,734
FLORIDA	106%	2,660	5,744	4,526	7,715
GEORGIA	100%	2,509	5,419	4,270	7,278
HAWAI'I *	100%	2,509	5,419	4,270	7,278
IDAHO	85%	2,133	4,606	3,630	6,186
ILLINOIS	111%	2,785	6,015	4,740	8,079
INDIANA	84%	2,108	4,552	3,587	6,114
IOWA	82%	2,057	4,444	3,501	5,968
KANSAS	88%	2,208	4,769	3,758	8,405
KENTUCKY	84%	2,108	4,552	3,587	6,114
LOUISIANA	99%	2,484	5,365	4,227	7,205
MAINE	85%	2,133	4,606	3,630	6,186
MARYLAND	100%	2,509	5,419	4,270	7,278
MASSACHUSETTS *	105%	2,634	5,690	4,484	7,642
MICHIGAN	105%	2,634	5,690	4,484	7,642
MINNESOTA *	91%	2,283	4,931	3,886	6,623
MISSISSIPPI	86%	2,158	4,660	3,672	6,259
MISSOURI	86%	2,158	4,660	3,872	6,259
MONTANA	85%	2,133	4,606	3,630	6,186
NEBRASKA	82%	2,057	4,444	3,501	5,968
NEVADA	113%	2,835	6,123	4,825	8,224
NEW HAMPSHIRE	85%	2,133	4,606	3,630	6,186
NEW JERSEY	103%	2,584	5,582	4,398	7,496
NEW MEXICO	90%	2,258	4,877	3,843	6,550
NEW YORK	106%	2,660	5,744	4,526	7,715
NORTH CAROLINA	82%	2,057	4,444	3,501	5,968
NORTH DAKOTA	85%	2,133	4,606	3,630	6,186
OHIO	89%	2,233	4,823	3,800	6,477
OKLAHOMA	87%	2,183	4,715	3,715	6,332
OREGON *	88%	2,208	4,769	3,758	6,405
PENNSYLVANIA	90%	2,258	4,877	3,843	6,550
RHODE ISLAND	95%	2,384	5,148	4,057	6,914
SOUTH CAROLINA	82%	2,057	4,444	3,501	5,968
SOUTH DAKOTA	80%	2,007	4,335	3,416	5,822
TENNESSEE	89%	2,233	4,823	3,800	6,477
TEXAS	105%	2,634	5,690	4,484	7,642
UTAH	90%	2,258	4,877	3,843	6,550
VERMONT	80%	2,007	4,335	3,416	5,822
VIRGINIA	87%	2,183	4,715	3,715	6,332
WASHINGTON	87%	2,183	4,715	3,715	6,332
WEST VIRGINIA	86%	2,158	4,660	3,672	6,259
WISCONSIN *	85%	2,133	4,606	3,630	6,186
WYOMING	85%	2,133	4,606	3,630	6,186
U.S. AVERAGE	100%	2,509	5,419	4,270	7,278

* These premiums are for the high cost–sharing plan only. They may not be appropriate for comparisons in states with a high HMO penetration (market share). Actuarial judgment should be exercised when using these estimates in states with large HMO penetration.

Source: HIAA

Estimates of Monthly Premiums*
Under the Proposed Health Security Act



Source: HIAA

* High cost-sharing (fee-for-serv.) Plan

DETERMINING THE BASE CLAIMS COST

1. **Base claims cost.** I developed the base claims cost for a single person from estimates from four commercial health insurance companies and one estimate I derived from the Tillinghast Group Rating Manual. The estimates were all based on the standard benefit package described in the 9/7/93 working-group draft (adjustments are made later for subsequent changes in the benefit plan) and the following assumptions:

- Precertification and concurrent review
- 12-month policy period beginning January 1, 1994
- No industry adjustment
- No COBRA, COB, or AIDS adjustments
- No geography (area) adjustment (i.e., claims costs are nationally representative)
- Standard room and board charges (semi-private)
- Census distribution similar to nonelderly U.S. population
- Guaranteed issue and mandated coverage
- Four-tier rating: single, couple, single-parent family and two-parent family
- Preexisting conditions covered
- No lifetime maximum

I averaged the estimates from the four commercial carriers and my estimate from the Tillinghast Group Rating Manual together to determine the average base claims cost for a single person under the proposed Health Security Act for each of the three standard benefit cost-sharing plans under the Act.

According to the Administration, the premium estimates presented with the proposed Health Security Act represent premiums related to the Act's high cost-sharing plan only. Therefore, only the premium estimates related to the high cost-sharing plan are presented in this memorandum.

Using data from the March 1992 Current Population Survey (CPS) regarding the distribution and average size of families currently insured (prepared for HIAA by Jack Rodgers of Price Waterhouse), and relative claims cost factors from the Tillinghast Group Rating Manual, I developed base claims costs for couples, single-parent families, and two-parent families using the expected claims cost for single persons.

The CPS average family size for all policies combined was 2.2 persons per policy. The average family size for a two-parent family was 4.0 persons. The average family size for a single-parent family was 2.8 persons.

The relative claims cost factors developed from the Tillinghast Group Rating Manual were:

(1) 1.00 for an insured;
(2) 1.16 for a spouse; and
(3) .39 for a child.

The rating factors (weights representing the ratio of the premium for a specific family status to the premium for a single person) derived from the combination of these average family size and relative claims cost factors were: 2.16 for couples, 1.70 for single parents, and 2.94 for two-parent families. The composite rating factor across all family status rating classes was 1.8.

The base claims costs developed using the above methodology and assumptions were:

Family Status	Base Claims Cost*
Single person	$1,927
Single-parent family	3,280
Couple	4,162
Two-parent family	5,665

(* See Appendix B, page 1.)

2. **Adjustment in average claims cost for change in distribution of policies as a result of expanding to universal coverage.** This factor corrects for the change in the average per capita claims cost that is a direct result of calculating a new weighted average claims cost when the mix of families is changed. (See Appendix B, page 2.)

After reforms, some individuals who are currently insured as single persons would become insured as part of a family under universal coverage, e.g., children and spouses that are not covered under an employee's policy would now be required to be covered. All family members would be on the same plan.

Uninsured single individuals and single-parent families would now be covered. These expansions of coverage and changes in family status are expected to alter the mix of policies by family status, but the average per capita claims cost should not change.

Not making this adjustment would artificially increase the estimated per capita claims cost and overstate premiums by about 1 percent of premium (Table 3, #2).

ADJUSTMENTS TO CLAIMS

3. **Adjustment to claims costs for migration (as when early retirees, the unemployed, individually insured, Medicaid recipients, and the uninsured join the Regional Health Alliance and are pooled with the current employer-sponsored pool after reform).** The proposed Health Security Act calls for establishment of Regional Health Alliances that would add at least four classes of insureds to the current employer-sponsored pool of insureds:

(1) Early retirees and unemployed persons currently covered under their prior employer's health plan,
(2) Persons covered under individual health insurance,
(3) Medicaid recipients, and
(4) The uninsured.

Using a distribution of the population by insured status from the March 1992 CPS and relative morbidity statistics (ratio of health care cost and utilization for each insured class to the cost and utilization of the active employee class), I determined a weighted average of the morbidity in the pool after the four classes were added to the active employee pool. (Appendix B, page 3.)

I split the employer-sponsored pool into two groups: the active employee pool and the retiree/unemployed pool. I did this for two reasons. First, the morbidity of the two classes is significantly different. HIAA research shows that health care expenditures are very similar for active employees and their dependents across all employer sizes. This is especially true after risk adjusting for health status of insureds by size of employer. However, health care expenditures of retirees and unemployed persons, and their dependents, who are still covered under a prior employer's health plan are very different from

those of active employees and their dependents. Second, early retirees and unemployed persons are usually covered by large employers, not small employers. Most employees who are being pooled in the regional alliance work for employers with fewer than 100 employees, i.e., small employers. So the majority of the pool we are going to be expanding will be a pool of active employees and dependents from small employers. Their cost (morbidity) is indicated best by the cost and utilization of an active employee pool. This is also the reason why the active employee pool is set as the standard with a relative morbidity of 1.00 or 100 percent.

I derived relative morbidities for the early retirees and persons with individual insurance from the relative morbidity of these populations in the 1987 NMES. Compared with the active employee population, the morbidities for these classes of insureds were 202 percent and 122 percent of the active employee pool, respectively.

The relative morbidity for Medicaid was assumed to be 100 percent, meaning that its cost is the same as that of active employees. This was one of the most difficult assumptions I had to make. In work done in conjunction with Price Waterhouse, I established that demographically, and on a risk-adjusted basis using a crude medical conditions risk adjuster, the Medicaid population should have a relative morbidity that is less than the active employee population. Countering my finding is Health Care Financing Administration (HCFA) and Medicaid data that indicate Medicaid enrollees--especially the cash recipients, who are the majority of Medicaid recipients--have an average claims cost that is significantly higher than active employees' claims cost. However, looking at current Medicaid experience to discern the future morbidity of Medicaid recipients can be misleading.

First, in this analysis I am assuming a mature market after reforms have been implemented. Just as I am assuming that all migrations and enrollment shifts have taken place to reach universal coverage--an event that will likely take several years --I had to look at the Medicaid costs in a mature market, after any initial high utilization periods might have passed.

Second, current Medicaid coverage does not include cost sharing. While many recipients would still have subsidies that cover much if not all of their cost-sharing obligations, some will not, and this will reduce utilization for recipients who would now have to make copayments.

Third, current Medicaid benefits are significantly different from the standard benefit package being proposed, especially regarding long-term care. This reduction in benefits will reduce costs.

Fourth, providers (for the most part) would be reimbursed for Medicaid patients at the same rate as they would be for non-Medicaid patients. (Although there would be some cost-sharing reductions that health plans may be required to "forgive.")

For all these reasons, I believe that the relative morbidity of the Medicaid population should not be any more than the average morbidity of the active employee population. Since this is a very uncertain assumption, however, I sensitivity tested for higher levels of morbidity.

For sensitivity testing, I developed a premium using a Medicaid morbidity rate of 120 percent, or 20 percent worse than the morbidity of the active employee population. The resulting premium was 2 percent higher than the best estimate, which used Medicaid morbidity of 100 percent (Table 3, #4). I also determined what the premium would be if there were no Medicaid recipients--as a sensitivity test. The resulting premium increased 1 percent over the best estimate (Table 3, #3).

For some of the same reasons, I assumed the relative morbidity of the uninsured was 100 percent of active employees' morbidity. This is clearly a much more conservative assumption for the uninsured than for the Medicaid population.

First, the RAND Health Insurance Experiment demonstrated that even three years after previously uninsured groups are insured (except for a short increase in mental health utilization in the first year), the previously uninsured were still utilizing services at a lower rate than the average insured population.

Second, although there is a greater percentage of high risk individuals among the uninsured than the insured population, the remainder of the uninsured are very low risks--over a quarter are children--offsetting the increased cost from the high-risk uninsured.

The United States Agency for Health Care Policy and Research (AHCPR) conducted a study of uninsured individuals who had either been denied insurance or had their coverage limited (such as through a waiver or preexisting condition exclusion) and found that only a little more than one-third of the uninsured had ever tried to get private coverage, and only about 2.5 percent had ever been denied coverage or had their coverage limited.

Research conducted by HIAA has shown that, on a risk-adjusted basis, the average risk of the uninsured is slightly less than that of the active employee pool.[2] Still, to be conservative, I tested sensitivity of the premium estimates to this assumption at the 120 percent morbidity level by developing a premium assuming both the uninsured and Medicaid populations had morbidity of 120 percent. The resulting premium was 5 percent higher than the best estimate (Table 3, #5).

Coincidentally, the Hewitt Associates' model uses a morbidity level of 120 percent of an insured large employer population (which includes some retirees) both for Medicaid recipients and for the uninsured. The Administration also uses levels of morbidity for these populations higher than 100 percent.

To test the sensitivity of the premium estimates to other migration assumptions, some additional estimates were made with varying assumptions:

- If the number of retirees/unemployed were 25 percent lower (the 25 percent is shifted to the active employee pool), the resulting premium would be 3 percent lower than the best estimate (see Table 3, #6).

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[2] Methodology for study is described in a September 3, 1993, memo from Tony Hammond to various researchers/actuaries on *Relative Risk of Population by Insured Status*.

- If the excess retiree morbidity (the amount by which the morbidity exceeds 100 percent) were reduced by 50 percent from 202 percent to 151 percent, the resulting premium would be 5 percent less than the best estimate (Table 3, #7).

- If the excess morbidity for both retirees and the individually insured were reduced by 50 percent, the resulting premium would be 6 percent less than the best estimate (Table 3, #8).

- If the excess morbidity for both retirees and the individually insured were reduced by 50 percent, and the uninsured and Medicaid populations had morbidity of 120 percent, the resulting premium would be 1 percent lower than the best estimate (Table 3, #9).

4. Reduction in cost shifting. This assumption is to reflect the reduction in costs that will occur when universal coverage is implemented and providers no longer have to overcharge their paying patients to cover the costs of underpaying or nonpaying patients. In effect it is a reduction in cost shifting, or, more accurately, it is a savings resulting from a reduction in uncompensated care costs for providers that gets passed along to insurers through lower health care costs.

- If the aggregate cost of migration were reduced by 50 percent, the resulting premium would be 6 percent lower than the best estimate (Table 3, #10).

Unfortunately, however, all cost shifting or uncompensated care--about 15 percent of claims cost--does not disappear. Medicare discounting, underpayment of premiums for Medicaid recipients, uncompensated care related to undocumented workers, and bad debt will still occur. The cost shifting will just be greatly reduced--except for Medicare cost shifting. The cost shift to private payers from Medicare is likely to continue. It is also questionable whether every dollar of reduction in cost shifting translates into a dollar of savings in premiums. Prior experience indicates that it is far more likely that only about half of these "savings" would materialize--7.5 percent of claims costs.

The Administration assumes a 10.5 percent "savings" from a reduction in uncompensated care. For conservatism, the assumption I used in the best estimate was the Administration's figure of 10.5 percent. For sensitivity testing, I used an assumption of 7.5 percent. The resulting premium was 3 percent higher.

5. Additional benefits in HSA. This adjustment reflects the increase in claims cost necessary to cover the expanded benefits included in the proposed Health Security Act that were not included in the Administration's 9/7/93 working-group draft. For example, preventive benefits were expanded to include periodic clinician visits for adults without cost-sharing. In discussions with the company actuaries who submitted cost estimates for my analysis and other actuaries, we decided that the new benefits added about 2 to 4 percent of additional claims cost.

The impact on premiums of having claims costs that are 1 or 5 percent higher was tested. As expected, premiums were 1 or 5 percent higher than the base, respectively (Table 3, #11 & #12).

ADJUSTMENTS TO NET PREMIUM (LOADING)

6. Surcharges and assessments. This adjustment to the premiums reflects direct additions to premiums, calculated as a percent of claims. This adjustment includes but is not limited to surcharges and assessments for:

- Guarantee fund assessments
- Surcharge for academic health centers
- Surcharge for graduate medical education
- Assessments for regional alliance's bad debt

This adjustment also includes additional margins needed as a direct result of the proposed Health Security Act. These margins include but are not limited to margins for:

- Contingency reserve for costs of Workers Comp and Auto
- Contingency reserve for underestimation of new expenses
- Uncertainty in pricing for universal coverage
- Uncertainty in pricing for expanded benefits
- Uncertainty in enrollment projections
- Medicaid underpayments
- Regional Health Alliance underpayments
- Uncertainty of risk adjustment mechanism
- Litigation costs resulting from reform

These adjustments could add 2 to 4 percent for the surcharges and assessments and another 3 to 5 percent, at least, for the additional margins. Taking the midpoint of both of these ranges, the best estimate assumption I used was 7 percent.

This assumption was sensitivity tested by using a 5 percent assumption, resulting in a premium that was 2 percent lower than the best estimate premium (Table 3, #14).

I included under changes in the expense ratio (in section 8 below) the addition to premiums for an alliance's administrative costs and the additional expenses related to reporting and compliance requirements.

7. **Current expense ratio.** This factor reflects the current combined operating expense ratio for group and individual business of 13.2 percent of premium.

This level of expense is distributed by type of expense as follows (from a preliminary HIAA study):

Claims administration, Plan administration, and Sales	11.1%
Risk/profit	1.5%
State tax	1.8%
Federal tax	0.8%
Net inv. inc.	-2.0%
Total	13.2%

It is also distributed by size of employer (number of employees) as follows (from a preliminary HIAA study):

	Expense	Pop
Group--95.2% of market		
Less than 25 EEs	25%	15%
25 to 99 EEs	18%	10%
100 to 499 EEs	14%	20%
500 to 2499	8%	30%
2500+	6%	25%
Individual--4.8% of market		
Individually insured	32.6%	100%
Composite	13.2%	100%

These estimates are national averages; the expense ratios of actual insurers and employers would depend on their specific circumstances.

8. Changes in Expense Ratio. This adjustment reflects administrative cost savings to insurers from using purchasing alliances and electronic claims submissions. It also reflects increases in administrative costs for purchasing alliance administration, new data reporting and compliance requirements, expanding coverage, and converting coverage for all self-insured employers with fewer than 5000 employees to fully insured, fully reserved policies.

The distributions above reflect the expense ratio for a mix of business that includes self-insured business as well as fully insured business, and expenses for all sizes of employers (ERs), including those with more than 5000 employees.

The first step is to adjust the distribution of expenses by size of employer to exclude employers with over 5000 employees. This adjustment needs to be done for the distribution above (which includes self-insured business) and for a distribution of expenses on a fully insured basis (because the adjusted expense ratio will fall somewhere between these two levels).

	% of Employees		Conditional
Employer size	All ERs	<5000	Distribution
Less than 25 EEs	14.3%	14.3%	16.7%
25 to 99 EEs	9.5%	9.5%	11.1%
100 to 499 EEs	19.0%	19.0%	22.2%
500 to 2499	28.6%	28.6%	33.3%
2500 to 4999	9.5%	9.5%	11.1%
5000+	14.3%		
Individually Insured	4.8%	4.8%	5.6%
Composite	100.0%	85.7%	100.0%

The first numerical column in the table above is the distribution for all employers. The second column is the distribution without employers with more than 5000 employees. The last column is the conditional distribution of employers with less than 5000 employees and individual insureds. This distribution can then be used to weight the distribution of administrative cost by size of employer using current expense ratios and expense ratios for fully insured business only.

	Expense Ratio		Conditional
Employer size	Current	Fully-Insd	Distribution
Less than 25 EEs	25%	25%	17%
25 to 99 EEs	18%	18%	11%
100 to 499 EEs	14%	16%	22%
500 to 2499	8%	13%	33%
2500 to 4999	6%	10%	11%
Individually Ins'd	32.6%	32.6%	6%
Composite	14.6%	17.1%	100%

This implies that eliminating employers with more than 5000 employees and eliminating self-insurance for the remaining employers would result in administrative costs between 14.6 percent and 17.1 percent.

The next adjustment reflects the administrative savings gained by using electronic claims submission and regional alliances.

	Before	After	Best Estimate
Claims administration,	11.1%	3.5%	3.5%
plan administration,		2.5%	2.5%
and sales		.5%	.5%
Risk/profit	1.5%	0 to 1.5%	1.5%
State tax	1.8%	1.8%	1.8%
Federal tax	0.8%	0 to .8%	.8%
Net investment income	-2.0%	-2.0%	-2.0%
Subtotal	13.2%	6.8% to 9.1%	8.6%
Plus 1% for compliance with new reporting requirements and regulations.			1.0%
Plus .5% to 2.5% for administrative costs for the operation of the regional alliance.			1.5%
	GRAND TOTAL		11.1%

This level of expense may seem higher than expected because of the additional 2.5 percent of expenses added for compliance and alliance administrative costs, and because the administrative cost of fully insuring and fully reserving groups is higher than the current administrative cost for large groups.

The next adjustment combines the change in the administrative cost by type of expense with the change in the administrative cost by size of employer. Since the reduction in the administrative cost by type of expense reduces the composite expense ratio by 16 percent, from 13.2 percent to 11.1 percent (i.e., 11.1/13.2 = .84), the same reduction can be applied to the composite costs by size of employer. Applying this adjustment reduces the range for the composite expense ratio to a range from 12.3 percent (.84 x .146 = .123) to 14.4 percent (.84 x .171 = .144). The midpoint of this range is 13.4 percent and is the assumption I used to determine the best estimate.

This level of administrative cost is slightly higher than the current level of 13.2 percent of premium. Sensitivity tests were done at the low estimate of 12.3 percent of premium (-0.9 percent change in expense ratio) and at the high estimate of 14.4 percent of premium (1.2 percent change in expense ratio) (Table 3, #15 and #16).

RESULTS OF SENSITIVITY TESTING

While much of the results of sensitivity testing are discussed in the numbered sections above, this section summarizes the results.

The assumptions that are the most likely to be different from what I assumed and to which my premium estimates are the most sensitive are:

- The base claims cost. A 1 percent change in premium will result from a 1 percent change in the base claims cost.

- The level of surcharges or assessments. A 1 percent change in premium will result from a 1 percent change in the level of surcharges or assessments. This would also be true for any premium taxes or operating costs that are explicitly defined as a percentage of gross premium.

- Savings from uncompensated care. A 1 percent change in premium will result from about a 2.5 percent change in the expected savings from uncompensated care.

- Morbidity level of the uninsured and Medicaid recipients combined. A 1 percent change in premium will result from about a 4 percent change in the morbidity level of the uninsured and Medicaid recipients combined.

- Aggregate cost of migration. A 1 percent change in premium will result from about an 8 percent change in the aggregate cost of migration.

- Number or morbidity of retirees. A 1 percent change in premium will result from a 10 percent change in the number or morbidity of retirees.

- Morbidity of Medicaid recipients. A 1 percent change in premium will result from a 10 percent change in the morbidity level of Medicaid recipients.

One of the assumptions to which premiums are not very sensitive is the change in distribution of policies by family status. Even if I did not make this adjustment, premiums would only change by 1 percent.

PROVISIONS AND REFORMS NOT QUANTIFIED

The number and complexity of health care reform proposals has greatly outstripped the available data, and the proposed Health Security Act (H.R. 3600; S. 1757) is no exception. Consequently, it was impossible to quantify certain provisions in the proposed Health Security Act. In some cases more research needs to be done and could be done if the necessary data were obtained. In other cases, the data are not available to credibly estimate the impact of certain reforms on the market.

Some of the provisions that would have a significant impact on premiums but are not specifically quantified in the preceding analysis are:

- Medicare enrollees joining Regional Health Alliances (especially those who are employed);

- Employers with more than 5000 employees joining Regional Health Alliances;

- Insurance reforms other than guaranteed issue and renewal, community rating, risk adjustment, and mandated/universal coverage;

- The impact of COBRA eligibles;[3]
- Multiple-earner families;[4]
- Efficacy of the universal coverage requirement;[5]
- Additional cost for point-of-service; and
- Induced retirement.[6]

All of these provisions would tend to increase rates.

No specific attempt was made to measure the proposed Act's effect on the solvency of employers and insurers.

The impact of state laws and regulations already promulgated could not be included in this study.

The scope of this study was limited to an analysis of the 1994 premiums released with the proposed Health Security Act. Some covariant effects could not be analyzed with the data available, for example, how geographic factors might change in the absence of other risk classification factors.

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[3] We can expect individuals leaving corporate alliances with COBRA premiums higher than the rates in a regional alliance to purchase coverage through the regional alliance, while those for whom rates under COBRA are lower will not do so. This creates an antiselection issue that is not addressed by the proposed Health Security Act.

[4] When one worker is eligible for coverage through a corporate alliance and another family member is eligible for coverage through a regional alliance.

[5] Even in Hawai'i universal coverage is not universal. Trying to get the last 1 percent enrolled can be very expensive.

[6] Individuals deciding to take early retirement now that the Health Security Act guarantees them health coverage paid for by the government and their employer.

COMMENTS FROM REVIEWERS

An initial draft of this memorandum was distributed to about two dozen interested actuaries and researchers for peer review.[7] I received responses from about half of them. Their comments and concerns are discussed below.

The previous section on provisions not quantified, which was not included in the initial draft, was added to respond to comments I received questioning whether certain issues were included in my analysis.

One reviewer asked why changes in the mental health and substance abuse benefits didn't reduce premiums between the September 7th working group draft and the proposed Health Security Act released in October.

> Some differences between the benefits outlined in the 9/7/93 draft and the proposed Health Security Act reduced premiums, while others increased premiums. Estimates using actual rate manuals showed some, but little, change between the cost of benefits outlined in the September 7th draft and the cost of benefits under the proposed Health Security Act, released in October. In discussions with company actuaries, the different benefits described in the Health Security Act added about 2 to 4 percent to the claims cost--and to the premiums.

One reviewer questioned why one estimate of the base claims cost was so much lower than the other four estimates.

> Obtaining a good estimate for base claims cost was one of my primary concerns from the very beginning. Experience of a single carrier is not necessarily credible. In order to address this problem, estimates were sought from a dozen companies of which only four responded. The four companies that responded have a diverse mix of business. However, as a reasonability check because of the small sample size, I prepared a separate estimate of expected claims cost from the Tillinghast Group Rating Manual and adjusted this estimate to match current national per capita claims cost trended forward to 1994. The estimate I produced in this manner was very close to three of the four estimates I received, giving me greater confidence in the higher estimates. As a last step, all five estimates of base claims cost were averaged together and the implied per capita claims cost was checked against nationally representative data for reasonability.

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[7] I am indebted to the following people for reviewing this memorandum and/or providing me with their comments:

Karen Bender, Employers Health
Howard Bolnick, Celtic Life
Cecil Bykerk, Mutual of Omaha
Sanford Herman, The Guardian
Leonard Koloms, Benefit Trust
Bill Lane, Mutual of Omaha
Jeff McDaniel, Nationwide
Mike O'Grady, Congressional Research Service
Jack Rodgers, Price Waterhouse
Maleta Simek, Celtic Life
Chuck Smith, The Principal
Bill Weller, Health Insurance Association of America
Dale Yamamoto, Hewitt Associates

One reviewer questioned why I used a child claim cost factor that was so low. He believed a factor of around 60 percent of primary insured claims cost would be more appropriate.

> This is a fair comment. The range of estimates I found for the child claim cost factor was from 39 percent to about 60 percent of the primary insured claims cost. Hewitt Associates used 50 percent for its estimates.
>
> When I sensitivity tested this assumption, there was some, but not a large difference in the premium estimates generated by using either 39 percent or 60 percent. Since the Administration's estimate of the family premium was considerably lower than my estimate and since there was not a lot of change in the final premiums in spite of which factor I used, I decided to use the smaller factor to be more conservative (i.e., to not accentuate the differences between our two estimates without good cause).

The same reviewer questioned my assertion that Medicaid cost shifting would continue after the Health Security Act was enacted.

> This is not a material assumption (no numerical factors are based on this assertion, so it would not change my estimate of the premium one way or the other). However, the proposed Health Security Act does establish premium discounts for Medicaid patients and requires health plans to "forgive" some cost sharing obligations of Medicaid cash recipients. When this occurs, costs can be expected to be shifted to other patients/insureds.

One reviewer pointed out that state-by-state estimates that were prepared using premium estimates for the high cost sharing plan, population figures, and area rating factors from the Tillinghast Group Rating Manual would not be appropriate for states with large populations and large HMO/managed care enrollment. In his opinion, the premium estimates I developed by state, which are listed in Table 5, would not be appropriate for states with greater than 25% HMO/managed care penetration, e.g., California.

> I believe this is a legitimate concern for states with a large HMO penetration (market share), but not necessarily states that have a large HMO population that is not a large percentage of the state population. The risk adjustment mechanism and lower cost-sharing for managed care plans will ameliorate some of this problem. However, these provisions will not adjust for all of the difference because only part of the difference is due to risk and cost sharing. Some of the difference is because the area rating factors are based on indemnity plans alone. Unfortunately, area rating factors by state that would be appropriate for all states, with their different levels of managed care, are not available. In spite of this limitation, the premium estimates by state are useful for comparing most states and may be useful for making comparisons to state-specific premium estimates for the Health Security Act for high cost-sharing plans. A note was added to Table 5 identifying this concern.

The same reviewer also felt that reductions in claims cost resulting from provider negotiations should be reflected in the claims cost estimates or adjustments to claims costs.

> While I would like to be able to score competitive market adjustments such as this, there is insufficient evidence for doing so. Some researchers and actuaries argue that discounts in one market segment just lead to cost shifts to other market segments. Others argue that gains are more due to biased selection than to discounts and cite evidence to support this. In the end, after risk adjustment, the real reductions in claims cost may actually just reduce trend increases in future years, not reduce the base claims cost (especially not for 1994). Further, I believe that I have already reduced the base claims cost more than enough by using the Administration's adjustment for uncompensated care. I don't believe it is necessary to add an additional explicit reduction for this factor because it may or may not occur and may already be reflected by my conservative estimates.

A couple of reviewers felt that the morbidity assumption used for Medicaid recipients was too low.

> This could have a material effect on my estimates, but it would only serve to widen the difference between my estimates and the Administration's. I believe that my approach, explained in section 3, is reasonable for the rating methodology I have used. In order to address the concerns of the reviewers, however, I have sensitivity tested this assumption at a morbidity level of 120% of the active employee morbidity. At this morbidity level for Medicaid recipients, premiums would only be 2 percent higher.

Another reviewer questioned my assumptions for the morbidity and number of retirees, pointing this out as a significant discrepancy between my approach and the Administration's.

> It is difficult to reconcile my estimates to the Administration's because our approaches are quite different. It is quite possible that our two approaches could be reconciled and would prove to be similar, but it was not possible to do so without being allowed to go into greater detail with the Administration's actuaries.
>
> Even though the number and morbidity of early retirees cannot be reconciled with the Administration's estimates, I believe the assumptions I used for both of these factors are consistent with each other. I used a larger population that included unemployed persons covered by their previous employer mixed in with the early retirees covered by their previous employer. The morbidity factor I used is appropriate for this population which is unemployed and early retirees mixed together.

Several reviewers felt that it was more appropriate to build national data up from rate manual data as I have done rather than from national health expenditure data as the Administration has done, while a few reviewers had concerns about reconciling both approaches.

> Theoretically, what I am trying to estimate could best be described as a national average rate manual. If I had perfect data for building a national average rate manual

from either insurer rate manual data or national health expenditure data, the end result should be the same. Thus, reconciling the two approaches becomes problematic only when we don't have perfect data and, thus, don't get to similar results. I believe that working with real claims data and the adjustments to rate manual data is more credible, reliable, and unbiased than starting with national health expenditure data and trying to adjust it to develop a national rate manual.

On a related subject, several reviewers and I discussed whether the rates for all adults should be the same or not.

Generally, a rate manual approach calls for developing a rate or factor for primary insureds, spouses, and children (adult males, adult females, and children) and building rates for each family category by using these factors. In this case, the rate for single insureds would be the rate for primary insureds. Likewise the rate for couples would be the sum of the rate for insureds plus the rate for spouses. And so on.

An alternative would be to treat all adults the same and only produce an adult rate and a child rate. Then the single insured rate would be the same as the adult rate, and the couple rate would be twice the adult rate.

Another alternative would be to segregate the claim costs by type of family and calculate a premium for each family type separately. In this case, the rate for single insureds would be the total claims and expenses for single insureds divided by the number of single insureds. The rate for couples would be the total claims and expenses for couples divided by the number of couples. The rate for two-parent families would be the total claims and expenses for these families divided by the number of two-parent families.

One of the big differences between the Administration's estimates and my estimates relate to these three approaches. I used the first approach because it is most appropriate for a rate manual approach. The Administration, in the proposed Health Security Act, implicitly requires using the second approach when it requires the couples' rate to be twice the single insured rate in a pure community-rated environment. This second approach would also be consistent with a rate manual approach and community rating.

In the Administration's development of premium estimates, a variant of the third approach is used. However, the third approach is inconsistent with its stated policy and proposed Health Security Act because it doesn't charge every adult the same rate.

The third approach is also inconsistent with pure community rating because it is quite possible that the reason the costs for adults in two-parent families are lower than the cost for adults that would be purchasing single and couple policies is because the adults in two-parent families are younger, on average.

One reviewer commented on the current distribution of expenses by type of expense (before reform) and suggested that a change be made in the table to make it more accurate.

I made the change suggested. It did not have a material effect on the aggregate expense levels or my premium estimate.

One reviewer asked whether the adjustment for surcharges and assessments was too high because it included surcharges for graduate medical education and academic health centers when these costs are already reflected in current claims costs.

> Theoretically, this would be true. In practice, there are two reasons why I still think this provision increases costs rather than just moves the same dollars from being in the claims cost to an explicit surcharge.
>
> First, the higher costs that academic health centers and graduate medical education add to current health care costs are not easily quantified. It may be higher or lower than the anticipated surcharges. Whatever it is, if it is less than the surcharge, it will likely grow to be as large as the surcharge as soon as these funds are available.
>
> Second, if these additional funds become available for education and health centers, it is unlikely that these funds will just be used to offset current sources of funding. We may see cost and utilization trends reduce a little in the future, but that would not reduce the current level or distribution of costs. It is far more likely that the current sources and level of financing will continue and the new funds will be used to increase spending in these areas. What happened to health care spending following the introduction of Medicare is a perfect example of this.

CONCLUSION

First, even without adjusting for benefit differences that would only exacerbate the difference, the Administration's premium estimates for the proposed Health Security Act are already at or less than the average employer premium in 1991, based on HIAA's Employer Survey. Second, from 1991 to 1994, health care cost and utilization (growth) trends, while slowing, have still sustained rates of growth that are considerably higher than inflation. For these three years combined, a health care trend of about 33 percent would not be unreasonable. Third, in the Administration's proposed Health Security Act, any reductions or cost savings are more than offset by expansions of benefits, expansions of coverage and new reporting/compliance requirements. Since any potential reductions in costs are more than offset by increases in costs, it is unlikely that a premium less than currently expected 1994 rates would be reasonable. Reforms would only have the potential of decreasing future rate increases. Consequently, there is no doubt that the Administration's estimates are understated. The only question is: By how much? Taken all together, this would indicate that the Administration's estimates are understated by at least one-third: i.e., the health care trend from 1991 to 1994.

Not all of the Administration's estimates are one-third lower than mine. The rate for single parents is 9 percent less than mine. The two-parent family rate is 40 percent less. In aggregate (a weighted average of its premium estimates by type of family compared to a weighted average of my premium estimates), its premiums are about one-third too low.

The fact that Hewitt Associates also found the Administration estimates to be about 25 percent understated is confirming.

There is a much greater difference between the Administration's two-parent family rate and my two-parent family rate than there is between our other rates. This is also true for Hewitt Associates' rates. I believe this discrepancy arises because of an inconsistency between the legislative language and the

Administration's rating methodology. As a result, the Administration's two-parent family premium is only 2.3 times its single person rate. A more reasonable multiplier might be about three times the single rate.

Most of the differences between the Administration's estimates and my own can probably be attributed to different assumptions regarding: the cost of including people not covered by health insurance (the uninsured), the cost of including early retirees and Medicaid recipients in the regional alliances, and operating costs (including assessments and surcharges). There is also a significant difference in how claims costs are distributed by type of family. Some of these differences increase premiums while others reduce premiums. The net effect of all of the differences leads to premiums that are on-third less than my estimates.

However, it is very difficult to compare assumptions and methodologies in order to identify differences between my rating methodology and the Administration's since the Administration has not released an actuarial opinion and an actuarial report. An actuarial opinion would establish that a qualified actuary has looked at the assumptions used to develop the Administration's premiums and deemed them to be reasonable and a fair representation of the expected cost of the Administration's standard benefit plan. An actuarial report would clearly identify the assumptions and reasoning that went into reaching that actuarial opinion so that an independent actuarial review of the Administration's methods and assumptions could be conducted by other actuaries.

Obvious questions arise from these findings. If the Administration's premium estimates are one-third too low:

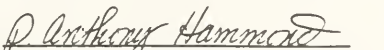
1. What does this mean for the Administration's estimates of subsidies for low-income persons and employers?

2. Will a larger proportion of the population pay more for health insurance after reforms than the Administration has estimated?

3. What would happen if the Administration's estimates were used as the basis for its proposed premium caps?

The premium estimates I have developed using the methodology described above are reasonable and are appropriate for comparison to the premium estimates the Clinton Administration presented with the proposed Health Security Act.

This opinion is limited by what is known about the assumptions the Administration used in developing its premium estimate and the provisions of the proposed Health Security Act (released in October 1993). If these were to change, my estimates and comparisons might also be different.



P. Anthony Hammond, ASA, MAAA

Appendix A

Comparing the HIAA premium estimates to the:

Administration's premium estimates:

- The HIAA premium estimates are 30 to 67 percent higher than the Administration's.

  Compared to the Administration's estimates of $1,932 annually for a single person and $4,360 for a two-parent family, HIAA's estimates are 30 percent and 67 percent higher, respectively. This would imply that the Administration's estimates are understated by 23 and 40 percent, respectively, (or about one-third) compared to our estimates.

  Not all of the Administration's estimates vary from HIAA's estimates so much. The rate for single parents is only 9 percent lower than ours.

- Most of the differences between the Administration's estimates and HIAA's can probably be attributed to different assumptions regarding:

  (1) The cost of including people not now covered by health insurance (the uninsured);

  (2) The cost of including early retirees and Medicaid-eligibles in the regional alliances;

  (3) Operating costs (including assessments and surcharges); and

  The Administration uses a 15% load while we used a 20.5% load. The proposed Health Security Act adds an additional 7% load to current operating costs of about 13% of premium.

  (4) A difference in how claims costs are distributed by type of family.

  Some of these differences increase premiums and some reduce premiums. The net effect of all of the differences leads to premiums that are one-third less than HIAA's estimates.

- While there are differences in some of the other assumptions mentioned above, the Administration's estimate of base claims costs appears to be very similar to ours.

- The HIAA premium estimates are 3 to 5 percent higher than the Hewitt Associates' estimates.

  Compared to the Hewitt Associates' estimates of $2,440 annually for a single person and $6,946 for a two-parent family, our estimates are only 3 and 5 percent higher, respectively. This is well within a reasonable level of difference.

  Hewitt's Congressional testimony on its estimates also states that "the cost of the standard benefit package would be about 5 percent higher in 2001 than the initial package because of scheduled changes under the Health Security Act for added mental health benefits and adult dental [benefits]." This would put its estimate even closer to ours.

- Although the Hewitt and HIAA estimates are very close in aggregate, there are still differences in the specific assumptions we used. The differences between the Hewitt Associates' estimates and ours can be attributed to different assumptions regarding:

  (1) The cost of early retirees, Medicaid and uninsured persons joining the regional alliances;

  (2) Operating costs (they used 10 percent);

  (3) The demographic composition of U.S. population (this has very little impact on rates in aggregate);

  (4) A major difference in recognition of the savings from uncompensated care (and elimination of Medicaid cost shift); and

  Hewitt used a 1.5 percent reduction for savings from uncompensated care and a 3.5 percent reduction for elimination of Medicaid cost shift.

  The HIAA estimates are based on the Administration's assumption of a 10.5 percent savings from uncompensated care (for conservatism) but don't explicitly recognize any reduction for elimination of Medicaid cost shifting.

  Hewitt's assumptions for uncompensated care and Medicaid cost shifting make Hewitt's premiums 5.5 percent lower than HIAA's. Hewitt's assumption for the cost of the uninsured and Medicaid joining the regional alliances raises premiums about 6 percent. So the two assumptions almost offset each other when comparing them to HIAA's premiums.

  (5) A different relative claims cost factor for children that makes the HIAA single-parent rate less than the Hewitt single-parent rate while all other HIAA rates are slightly more than the Hewitt rates.

  Hewitt uses a child factor of 50 percent of primary insured claims while HIAA uses a factor of 39 percent.

Lewin-VHI's premium estimates:

- The Lewin-VHI premium estimates cannot be directly compared to our estimates, the Administration's estimates or Hewitt Associates' estimates.

  The Lewin estimates are for 1998, whereas the other estimates are for 1994. Lewin's premiums are for all standard benefit plans while the Administration and HIAA estimates are for the high cost-sharing plan only. Lewin also makes the unreasonable assumption in developing its premium estimates that cost controls will be 100 percent effective.

- Some reports have indicated that the Lewin study validates the Administration's figures. This is simply not the case. Even if the Administration's premium estimates are only 17 percent too low as the Lewin study suggests, this would represent about one sixth of the non-Medicare health care costs in the United States--or about $100 billion. A discrepancy of that size hardly classifies as a validation.

Appendix B

Premiums in Regional Health Alliances
Under the Clinton Administration's Proposed Health Security Act

1. Base Claims Cost–high cost sharing (based on benefits in 9/7/93 draft)

Estimated Claim Cost	Single $1,927	Two parent $5,665	Single Parent $3,280	Couple $4,162	
Carrier A	$1,920		Relative Claims		
Carrier B	$2,000		Cost Factors:		
Carrier C	$1,739		1.00 insured		
Carrier D	$1,989		1.16 spouse		
HIAA (est.)	$1,987		0.39 child		
Average	$1,927				Total
Policies(mil's)	28.7	15.8	10.4	9.2	64.1
Frequency	44.8%	24.6%	16.2%	14.4%	100.0%
Family size	1.0	4.0	2.8	2.0	2.2
Rating factor	1.00	2.94	1.70	2.16	1.8

Sources: HIAA member companies, Tillinghast Group Rating Manual, and Price Waterhouse tabulations of March 1992 CPS

2. Adjustment to Average Claims Cost for Change in Distribution of Policies as a Result of Extending Coverage to Universal Coverage

Claims cost	$1,927	$5,665	$3,280	$4,162	3388.8
Family size	1.0	4.0	2.8	2.0	2.2
Current claims cost per capita					$1,558
After Reforms:					
Policies	48.3	26.5	11.2	17.2	103.2
Frequency	46.8%	25.7%	10.9%	16.7%	100.0%
Family size	1.0	3.9	2.8	2.0	2.2
Rating factor	1.00	2.90	1.70	2.16	1.8
Claims cost	$1,927	$5,590	$3,280	$4,162	3387.0
Claims cost per capita with new distribution					$1,575
Adjustment for change in distribution of policies					0.989

Sources: HIAA member companies, Tillinghast Group Rating Manual, and Price Waterhouse tabulations of March 1992 CPS

3. Adjustment to Claims Cost for Migration (for early retirees, unemployed, Medicaid, uninsured)

Nonelderly (by Insured Status)	Percent of Population*	Relative Morbidity**
Employer Sponsored		
Employed	57.6%	100%
Early Retiree/Unemployed	10.6%	202%
Other Privately Insured	6.4%	122%
Medicaid	8.8%	100%
Uninsured	16.6%	100%
	100.0%	112%

* Source: HIAA tabulation based on March 1992 Current Population Survey and HIAA Source Book.

** Source: HIAA and Mathematica calculations from 1987 National Medical Expenditure Survey

Premiums in Regional Health Alliances
Under the Clinton Administration's Proposed Health Security Act

4. Other Adjustments to Claims Cost

a. Reduction in cost shifting	−10.5%	savings from uncompensated care
b. Addt'l benefits in HSA	3%	benefits in HSA but not in 9/7/93 draft
Total	−8%	

5. Adjusted Claims Cost

	Single	Two parent	Single Parent	Couple	Composite
Claims Cost	$1,927	$5,590	$3,280	$4,162	$3,387
Change in distribution		−1%			
Cost of migration		12%			
Reduction in cost shifting		−11%			
Addt'l benefits in HSA		3%			
Total Adjustment		4%			
Adjusted Claims Cost	Single	Two parent	Single Parent	Couple	Composite
	$1,997	$5,794	$3,399	$4,314	$3,510

6. Adjustments to Net Premium (Loading)

a. Surcharges/assessments	7.0%	incl. margins for WC, auto, guar. funds,..
b. Current Expense Ratio	13.2%	current retention level
c. Change in Expense Ratio	0.2%	WEDI, Alliances, fully insured vs ASO
Total Loading	20.4%	

7. Average Premium After Reforms

	Single	Two parent	Single Parent	Couple	Composite
Adjusted Claims Cost	$1,997	$5,794	$3,399	$4,314	$3,510
Loading Factor	20.4%				
Adjusted Premium	$2,509	$7,278	$4,270	$5,419	$4,410

8. HIAA Estimate versus Administration Estimate

	Single	Two parent	Single Parent	Couple	Composite
HIAA	$2,509	$7,278	$4,270	$5,419	$4,410
Administration	$1,932	$4,360	$3,893	$3,865	$3,090
% understated	−23%	−40%	−9%	−29%	−30%

– P. Anthony Hammond
– 12/3/93

PREPARED STATEMENT OF W. DAVID HELMS *

Policy makers face a fundamental choice about how to expand health insurance coverage to the uninsured. Given that the majority of Americans currently get their health insurance through employers, some believe that universal coverage could be achieved by encouraging non-insuring firms to purchase it for their employees voluntarily—thereby avoiding the need to impose mandates. This testimony reviews results from several demonstration programs and state initiatives that tested the effectiveness of various incentives, including direct and indirect premium subsidies, tax credits, limited benefit (including so-called "barebones") insurance plans, and buying cooperatives. The policy implications from this assessment are as follows:

1. Voluntary approaches to making health insurance more affordable and available will not be sufficient to achieve universal coverage.
2. If the voluntary approach continues to be pursued because there is insufficient political support for a system of universal coverage, the following steps should be taken to increase financial access—with the clear understanding that while more of the uninsured will receive coverage through a combination of these measures, the goal of universal access will not be achieved:

- Stabilize the small-group insurance market by prohibiting the medical underwriting which excludes firms or individuals from coverage, guaranteeing the availability and renewability of coverage; and eliminating pre-existing condition exclusions for those who are continuously insured.
- Establish state or regional purchasing cooperatives for small firms and individuals to consolidate their market power and reduce total administrative costs.
- Provide direct subsidies or tax credits for low-income individuals and families on a sliding scale up to 200 percent of the poverty level.
- Ensure that affordable individual insurance coverage is available for those not working or those not covered by an employer-sponsored plan, including part-time and seasonal workers.
- Establish a uniform federal income standard for Medicaid to cover all individuals and families below 100 percent of the poverty level.

I. THE ROBERT WOOD JOHNSON FOUNDATION'S HEALTH CARE FOR THE UNINSURED PROGRAM

With support from the Robert Wood Johnson Foundation, states and non-profit groups tested a variety of methods to make health insurance both more affordable and available to uninsured small businesses and individuals under the Heath Care for the Uninsured Program (HCUP), which began in 1986.[1] Eleven demonstration projects became operational under the program: ten developed new insurance products or subsidized existing products, and one developed a health insurance information and referral service.

Market surveys conducted by the projects revealed that the cost of insurance is the major obstacle for small firms. Many small businesses have thin profit margins and the uncertainty of both future income and expenses leads many new or marginal business owners to avoid the fixed cost of monthly insurance premiums. Also, many low-wage employees hired by these firms would not be able to contribute very much to the cost of insurance premiums if coverage were available. The results of these market surveys displayed in Table 1 have been confirmed in many subsequent studies of why small employers do not offer insurance.

Strategies for making health insurance affordable: The projects' market research found that cost was the most significant barrier preventing small employers from obtaining health insurance. There are two basic ways to lower the cost of insurance: either offer less coverage or provide subsidies. Projects that were unable to offer subsidies instead limited the scope of services covered in their plans, increased cost sharing, used limited provider networks, or secured substantial discounts from hospitals. Projects able to fund direct and indirect subsidies generally provided more comprehensive benefits with only modest cost sharing. The strategies used to make the premiums more affordable are described below:

- **Limited benefits.** Two approaches were used to limit benefits: (1) eliminate certain services from the benefit package, such as mental health care, alcohol and substance abuse treatment, dental and vision care, durable medical equip-

*The Alpha Center is a nonprofit, nonpartisan health policy organization providing technical assistance and analysis to governments, foundations and private organizations. The views expressed in this statement are solely those of the author and should not be attributed to the Alpha Center, its trustees or its sponsors.

ment and (2) limit the volume of covered services per year, such as the number of days for inpatient services or visits for outpatient services.

- **Major cost sharing.** Another benefit design strategy for reducing premiums was to require patients to pay for a higher portion of the health care services they received, in the form of either deductibles and coinsurance charges or copayments.[2]
- **Limited provider networks.** All of the projects that developed new insurance plans used health maintenance organizations (HMOs) or preferred provider organizations (PPOs) to manage care. Several projects further restricted enrollees' freedom of choice by channeling them to a select group of less costly providers, including community-based clinics and/or public hospitals.
- **Direct premium subsidies.** Direct subsidies were used to reduce the cost of individual and family premiums for eligible small firms which had not previously offered insurance to their employees. Maine, Michigan, Washington and Wisconsin provided premium subsidies for those up to 200 percent of poverty on a sliding fee scale. Florida also used state funds to "buy-down" the cost of dependent coverage.
- **Indirect subsidies.** Several states used indirect subsidies to reduce the cost of premiums charged to small groups. These states performed or subsidized administrative, marketing, and pooling functions; paid for or facilitated the purchase of reinsurance; or provided stop-loss protection. Florida estimates that as a result of both the state performing these administrative functions and their ability now to negotiate as a large employer, the cost of their comprehensive HMO benefit package is about $100 less per family per month than comparable plans now available to small firms.
- **Provider discounts.** Some projects negotiated discounts from providers, especially hospitals. In return, the project channeled patients to participating hospitals which received the reduced payment for treating patients who might otherwise be uninsured and unable to pay. While provider discounts did help to lower premiums, projects found it difficult to replicate such commitments when trying to expand into other communities.

Different projects used different combinations of these approaches, as shown in Table 2:

Strategies for Making Health Insurance More Available: These demonstrations were limited in their ability to address insurers' underwriting and exclusionary practices, which require systemwide reform of the small-group health insurance market. The projects did, however, test new mechanisms for creating larger and more stable insurance pools and for marketing to uninsured small firms.

- **Limited medical underwriting and industry exclusions.** Some projects sought to limit the exclusionary practices used by many insurers to reduce the perceived risks of the small-group market. For example, the Arizona project created a new insurance product with no medical underwriting but did impose a waiting period for pre-existing conditions. The Florida project permits women to obtain pregnancy-related coverage through their sixth month of pregnancy. The projects did not exclude many of the types of small businesses that are typically red-lined (e.g. bars and taverns, mining, hair salons) and some included businesses in their first year of operation.
- **Larger, more stable insurance pools.** Creating larger and more stable insurance pools was used to spread risk more broadly and thereby lower the cost of insurance available to small firms. To do this, the projects funded some administrative functions such as enrollment and reinsurance costs until the number of enrollees was large enough that these costs were expected to approach those of large groups.
- **Innovative, aggressive marketing and advertising.** In general, the projects found that uninsured small employers were a very "tough sell." Uninsured small employers are hard to reach. Without full-time benefits managers on their staff, they require more education, information, follow-up, and support—especially during the application process. The most successful projects used professional advertising firms to develop marketing materials and campaigns and used public relations efforts to generate additional media coverage.

Results: Premiums. All of the projects offered premiums significantly below national averages for HMO benefit plans. For the plans targeted to uninsured small businesses, premiums ranged from 9 to 60 percent below market rates; most ranged from 25 to 50 percent below market rates. Premium data on the Washington Basic Health Plan show that subsidizing a comprehensive health plan for individuals below 200 percent of the poverty level can be very expensive. As the Basic Health

Plan is not offered through employers, there are no employer contributions to the premium which necessitates a substantial state subsidy to reach the lowest-income persons.

Results: Enrollment. In total, the projects enrolled over 54,000 persons, including about 30,800 employees and dependents through 6,700 small businesses and 23,500 individuals through the Washington Basic Health Plan. With a target market of firms with less than 25 employees, the projects were most attractive to very small employer groups: the average enrolled firm size is 2.7 employees, and the average enrolled group (including dependents) is 4.6 persons. Note that all but one of these projects limited their enrollment to previously uninsured firms—the hardest part of the market to reach. The enrollment in plans offering very limited benefit products was small. Through surveys and focus groups, the projects found that small employers generally want benefit packages similar to those of large employers. If they were going to purchase health insurance for their employees, they wanted comprehensive coverage, not just catastrophic. (See Table 3 on page 6 for enrollment data.)

Results: Market Penetration. With the modest enrollment reported above, the projects achieved only very small market penetration as shown in Chart 1 on page 6. The largest market share was achieved in Tampa, where approximately 17 percent of uninsured firms with 2 to 25 employees enrolled in the Florida Health Access Corporation. (FHAC is a state-supported health insurance buying cooperative that negotiates with insurers on behalf of small businesses.) The other three sites achieved much lower market shares, ranging from 2 to 5 percent.[3] These projects were able to reach a small niche in the previously uninsured market—firms that were, on average, smaller and younger with relatively low revenue, but anticipated growth and the need to attract employees who expect health insurance benefits.

Results: Utilization. The early experience of these projects indicated that insurers' fear of adverse selection for the small-group market may not be justified. Participants' initial use of health services has been lower than anticipated and lower than national averages for three common measures of use of inpatient services: discharges per thousand members, inpatient days per thousand members, and average length-of-stay. However, enrollment in the demonstration projects is still relatively low, and further analysis adjusting these data for health status, demographic characteristics, and other factors is needed to compare them more accurately with the utilization experience of enrollees in other plans. The Robert Wood Johnson Foundation is currently supporting research to compare utilization in several of these demonstration projects to that in other pools of small businesses.

II. OTHER VOLUNTARY EFFORTS TO EXPAND HEALTH INSURANCE COVERAGE

A. California

In October 1992, the California Assembly enacted legislation to create a voluntary "health insurance purchasing cooperative," call the Health Insurance Plan of California (HIPC), for small businesses with 5 to 50 employees working at least 30 hours per week. The program began enrollment in July 1993, offering 3 PPO and 15 HMO plans that provide a set of benefits comparable to the state employees' health plan, with varying levels of cost sharing. The lowest priced HMO plan is estimated to cost about 15 percent less than comparable plans outside the HIPC. Enrolled groups pay monthly premiums to the HIPC's contracted third-party administrator, which in turn pays the health plans and remits an administrative fee to the HIPC. This administrative fee is about 3 percent of premiums. The program receives no subsidy from the state. It provides coverage to both uninsured and previously insured firms.

As of January 1994, California's HIPC had enrolled 1,909 firms covering 32,587 lives. Project staff believe that the early high market response demonstrates the value of public support for this program by the Governor and other state leaders as well as recent national promotion of the "HIPC" concept.

In comparing the California program to earlier efforts to expand employer-sponsored health insurance coverage, it is important to note that the HIPC accepts firms that have already been providing insurance benefits to their employees, while most of the earlier programs restricted enrollment to uninsured firms. Seventy-eight percent of firms enrolling in the HIPC had previously offered health insurance to their employees—only 22 percent had been uninsured. By contrast, nearly all of the demonstrations supported under the RWJF Health Care for the Uninsured Program required small firms to have been uninsured for three or more months prior to enrollment, so as to avoid "competing" with other insurers for this underserved and hard-to-reach segment of the market. The California results also indicate that a significant number of small employers may find that buying coverage through the HIPC represents a better value than other health insurance arrangements.

B. Oregon

In 1989, the Oregon Legislature created the Small Employer Insurance Pool to provide an affordable, limited-benefit insurance product to uninsured small firms. At present the plan costs $55 dollars per person per month. In order to keep this low price, the state has allowed insurers to trim back benefits even further and increase cost-sharing provisions. The state also offers a tax credit for employers that buy these products, with the amount of the credit diminishing each year over a five-year phase-out period. Currently, about 18,000 persons are enrolled, far short of the state's goal of 150,000.

C. New York

In 1989, New York State established two pilot projects to test the feasibility of offering subsidized health insurance plans to non-insuring employers with twenty or fewer workers. Under these demonstrations, the state and the employer each pay one half of the premiums. The benefit packages include coverage for inpatient hospitalization including related diagnostic and therapeutic services, 60 visits per year for substance abuse, home care services, and authorized emergency services. One pilot in the Albany region is administered by the Community Health Plan (CHP), and a second program in Brooklyn is cosponsored by the Health Insurance Plan (HIP) of Greater New York and the Brooklyn Economic Development Corporation.

Program evaluators concluded that despite offering a 50 percent subsidy to employers, the enrollment response was quite low.[4] Their study determined that the subsidized health insurance products increased the number of small firms offering insurance by only 3.5 percent. Even if all eligible firms had been aware of the program, their calculations suggest that enrollment would have been no higher than 16.5 percent of the target market. Although the analysis covered only the first year of the demonstration program, the total number of firms purchasing insurance through the second year suggests that the effectiveness of the program did not increase over time. Even with more liberal plan provisions and subsidies to bring premiums 50 percent to 75 percent below market rates, the results indicate that such a voluntary program induces few small employers to begin offering health insurance benefits to their workers.

D. State Bare-Born Insurance Products

Thirty-six states have enacted laws that waive some or all mandated benefits for health insurance plans and allow insurers to create basic or "barebones" insurance plans for small employers. The objective is to allow insurers to drop certain benefits for small-group products, thus enabling them to lower prices for this underserved market segment. The most commonly waived mandated benefits are services for alcohol and substance abuse, insurance continuation or conversion, and providers such as chiropractors. This strategy has been particularly attractive to state legislators because it requires neither additional public expenditures nor major government intervention in private insurance markets.

There are numerous variations in the "barebones" programs across the states. For example, some states have specified the minimum benefits which insurers must offer. Several used increased cost-sharing (i.e., deductibles, coinsurance, and copayments) as an additional strategy for lowering premiums. A few states enacted tax incentives together with waived mandates to encourage small employers to purchase these special plans.

"Barebones" policies have realized only limited success in extending insurance protection to the uninsured. According to the Blue Cross & Blue Shield Association, "the results are decidedly mixed: well-designed, strongly promoted policies attract significant numbers of consumers over time, while the others do not."[5] As of December 1992, the great majority of "no frills" policies had been sold in three states: Pennsylvania (31,784), Oregon (14,278) and Washington (4,968). Not surprisingly, these are also the states where Blue Cross and Blue Shield Plans have had a strong commitment to basic benefit policies for the longest period of time.

While a large number of small business owners and individuals have expressed interest in the barebones plans, only a few had actually purchased the plans as of March 1993, as reported by the Families USA Foundation.[6] In Oklahoma, where there were almost 40,000 inquiries, only 119 groups purchased the insurance. Likewise, in Maryland, where there were almost 9,000 inquiries about the plans, only 357 groups and individuals applied. The large number of inquiries is evidence that many people are interested in obtaining insurance, but the small number of enrollees may indicate that these individuals are interested only in obtaining comprehensive coverage.

III. CONCLUSION

The critical question raised by these voluntary efforts to entice small employers to purchase health insurance for their employees is: why don't they work? Some employers reported that they feared the state governments would retract the subsidies. As evidenced by what subsequently happened in Maine, Michigan, and Wisconsin, they were right. Although the projects did not test whether subsidies greater than 50 percent would achieve a better response, these would be costly for government and, based on the experience outlined in this testimony, probably disappointing as well.

It could be argued that, had the RWJF Health Care for Uninsured projects operated in a more reformed environment with insurance market reforms and purchasing cooperatives at least for small firms, enrollment might have been higher. But the fact that uninsured workers in small firms are primarily low-wage workers means that they require heavy subsidizes. As a result, there is little evidence that voluntary efforts alone can resolve the uninsured problem.

Given these and other results cited in this testimony, it is easy to understand why states have moved on to initiate more comprehensive health care reforms. While there are unique circumstances in each, together the states face continued escalation in health care costs, an increasing number of uninsured as private insurance covers fewer workers and their families, and a recognition that the incremental steps reported here together with Medicaid expansion were not going to achieve the goal of universal access.

So, given how difficult it will be to achieve universal coverage, I would like to conclude with a comment on why it is so important. Personally, I would hope that our country can at last make this commitment to all of its citizens because it is simply the right thing to do. But it is important also for the practical reason that effective cost control—through managed competition, explicit expenditure limits, or a version of both—requires a system of universal coverage without free riders.

NOTES

1. W.D. Helms, A.K. Gauthier and D.M. Campion, "Mending the Flaws in the Small Group Market," *Health Affairs* (Summer 1992) 8–27.
2. Coinsurance requires plan participants to pay a fixed percentage of the cost of covered services, usually to a maximum out-of-pocket amount. A copayment is a nominal charge per service used, and may not count toward the plan's out-of-pocket maximum.
3. C.G. McLaughlin and W.K. Zellers, "The Shortcomings of Voluntarism in the Small-Group Insurance Market," *Health Affairs* (Summer 1992) 28–40.
4. K. Thorpe et al., "Reducing the Number of Uninsured by Subsidizing Employment-Based Health Insurance," *Journal of the American Medical Association* (February 19, 1992) 945–948.
5. S.S. Laudicinia, *Impact of State Basic Benefit Laws on the Uninsured.* Washington, D.C.: Blue Cross Blue Shield Association, (December 1992) 11.
6. Families USA Foundation, *No Sale. The Failure of Barebones Insurance.* Washington, D.C.: Families USA Foundation, (July 1993) 4.

Table 1

Relative Importance of Reasons Small Employers Give for Not Offering Health Insurance

Cost:	*Rank*
Too Expensive	1
Firm Not Sufficiently Profitable	4
Workforce Considerations:	
Many Employees Insured Elsewhere	2
Employees Can Be Hired Without Providing Insurance	3
Employees Don't Want It	5
High Employee Turnover	8
Insurance Market:	
Cannot Find An Acceptable Plan	6
Company Turned Down: Too Small	7
Lack of Information/Difficulty Judging Plans	9
Employees Cannot Qualify: Pre-existing Conditions	10
Company Turned Down: Type of Business	11

Source: Alpha Center. Reprinted from W.D. Helms, et al., "Mending the Flaws in the Small Group Market," *Health Affairs*, (Summer 1992) 8-27.

Table 2

Strategies for Making Health Insurance More Affordable

Project	Insurance Plan Innovations			Subsidy			
	Limited benefits options	Major cost sharing	Very exclusive provider network	Direct premium	Indirect: pooling, admin., reinsur.	Discounts from providers	Link to high risk pool
Alabama	▬		▬			▬	
* Arizona	▬				▬	▬	
Colorado		▬				▬	
* Florida				▬	▬	▬	
* Maine				▬	▬	▬	▬
* Michigan				▬		▬	
Tennessee	▬					▬	
Utah		▬	▬		▬	▬	
* Washington				▬			
* Wisconsin				▬			▬

* Project sponsored by state government.

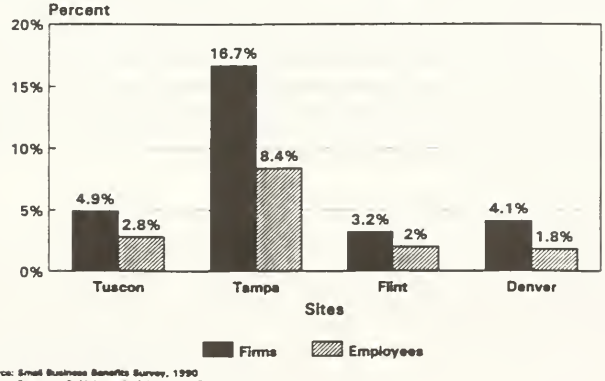
Source: Alpha Center. Reprinted from W.D. Helms, et al., "Mending the Flaws in the Small Group Market," *Health Affairs*, (Summer 1992) 8-27.

Table 3
Enrollment and Firm Size, June 1993

Project*	Months Enrolling	Lives Enrolled	Firms Enrolled	Average Firm Size	Average Group Size
Arizona	65	7,704	2,316	n/a	3.3
Maine	54	858	326	2.4	4.0
Washington	53	23,541	n/a	n/a	n/a
Tennessee	50	730	189	2.0	3.9
Florida	48	12,410	2,859	2.3	4.3
Colorado**	45	7,071	720	4.5	9.9
Utah	44	1,823	311	2.5	6.0
Alabama	38	193	30	3.8	6.4
Totals		54,330	6,751	Avg 2.7	Avg 4.6

*Does not include projects in Michigan and Wisconsin, which ended in March and June 1991, respectively.
**Data for SCOPE program in Colorado as of 12/31/93

Chart 1
Market Penetration of HCUP-Sponsored
Plans for Firms and Employees, 1991



Source: Small Business Benefits Survey, 1990
Catherine G. McLaughlin & Wendy K. Zellers
University of Michigan, School of Public Health

PREPARED STATEMENT OF MARY NELL LEHNHARD

Mr. Chairman, and members of the committee, I am Mary Nell Lehnhard, Senior Vice President, of the Blue Cross and Blue Shield Association, the coordinating organization for the 69 independent Blue Cross and Blue Shield Plans. Collectively, the Plans provide health benefits protection for about 68 million people. I appreciate the opportunity to testify before you on the need to move forward with insurance reform. We believe reform is needed. It is needed *now*.

Insurance reform holds the foundation to solving the twin dilemma that is at the heart of the national debate over health care reform: controlling costs without diminishing quality and achieving universal coverage. Although insurance reform is not the entire solution to either of these problems, it is a necessary part of the solution to both. We must also move ahead with other needed reforms that will provide more secure health care coverage for all Americans.

BLUE CROSS AND BLUE SHIELD SUPPORTS INSURANCE REFORM

Insurance reform is the foundation for comprehensive federal health care reform. It will require health insurers and health care providers to manage the transformation of an industry that accounts for one out of every seven dollars of consumer spending, and more than eight million jobs. Make no mistake, however, this transformation is already underway. Private insurers, employers, health care providers, and consumers are ahead of government in changing the way we do business to address the needs of a changing market. States are moving ahead with reform efforts of their own. It is time for the federal government to join the effort to build a health care system for the twenty-first century.

Blue cross and Blue Shield Plans, along with many other insurers and health plans, are already moving on the development of new products to better manage costs and offer better value to subscribers. We are developing new partnerships with providers that for the first time create strong incentives to control costs and improve quality. We are developing and adopting new standards for administrative simplification and electronic data interchange that will lay the groundwork for the "information super-highway" of the future. We are developing and applying new methods of using data to manage costs and quality. Federal health care reform can support these efforts by establishing a high, uniform standard of accountability for all health plans. Delaying federal reform could needlessly dampen the pace of change in the private sector. Strong federal action will maintain the pace of reform.

We believe that the best, most effective strategy to contain costs while still meeting the needs of patients and consumers is the enactment of reforms that will permit true price competition—for the first time—in the financing and delivery of health care in this country. Price competition—not price controls—will result in lower costs and better quality.

FEDERAL STANDARDS TO REFORM THE INSURANCE MARKET

We believe strict federal standards for the market conduct of insurers is the first and most important step toward reshaping the health care market—and assuring fairness to consumers. New standards for health insurers both would guarantee the availability of insurance for all and bring about real price competition for the first time in the financing and delivery of health care. These standards must be the same in all states. Federal standards defining an accountable health plan should:

1. Require Accountable Health Plans to accept everyone regardless of their health status or employment;
2. Prohibit Accountable Health Plans from dropping people or groups when someone gets sick, and require insurers to offer continued coverage when a person loses his or her job;
3. Strictly limit the length and use of waiting periods for pre-existing conditions and prohibit them entirely for people who have been continuously covered;
4. Require Accountable Health Plans to offer a limited number of standardized benefit designs that will allow consumers to easily compare products without having to worry about the "fine print";
5. Require Accountable Health Plans to set premiums fairly and not penalize people who are sick or older;
6. Require Accountable Health Plans to comply with requirements for administrative simplification, including increased reliance on electronic data interchange and use of uniform claim forms; and,
7. Require Accountable Health Plans to provide consumers with standardized data on a health plan's quality of care and subscriber satisfaction rating to enable consumers to select a health plan based on quality and service, in addition to price.

These strict standards should be established by federal reform and enforced by the states. They must apply not only to insurers and health maintenance organizations, but also to self-funded plans. Self-funded plans must play by the same rules and be held to the same standards as accountable health plans. These federal standards would require all health plans to compete fairly. State enforcement is needed to accommodate the widely varying needs of very diverse communities.

I cannot emphasize strongly enough the significant impact that insurance reform will have on carrier practices and costs. The types of insurance reforms that I will discuss move the market toward competition based on price, quality and service, and away from competition based on risk selection. Risk selection undermines true price competition in health care. Under today's rules, it is easier for many insurers and HMOs to hold down costs by screening out high risk subscribers than by managing overall health care costs. Many insurers, if they have the choice, will invest in efforts to avoid high risk subscribers rather than invest in efforts to manage cost. Insurance reform will put an end to these practices, and will require health plans to compete on the basis of their ability to manage costs and improve quality.

By itself, however, insurance reform cannot achieve universal coverage. And without universal coverage, the full benefits of insurance reform will not be realized. We believe that some combination of individual and employer responsibility would be necessary to achieve universal coverage.

Similarly, insurance reform sets the stage for true price competition, but changes in the tax treatment of employer contributions for health benefits are needed to strengthen the incentives for employers, employees and individuals to weigh price more carefully when selecting a health plan. As price becomes more important to employer and employee consumers, health plans will make greater efforts to find more effective ways of managing costs.

MAKING THE TRANSITION TO ACCOUNTABLE HEALTH PLANS

Insurance reform will require fundamental changes. It will not occur overnight. It will require health plans and others to develop new ways of doing business. It is critical that the transition period move steadily and swiftly, but in an orderly way, to a restructured health care delivery system.

The changes that reform will bring about will challenge health plans and consumers. A transition period is needed to allow both to meet the challenge:

1. Health plans will have to modify their benefit design to comply with the requirement for a standard benefit product and to adjust their premium to reflect the new benefit level. To implement these changes health plans will need to educate consumers, develop a new rate structure, and obtain any necessary regulatory approvals.

2. Health plans will need time to phase in community rating for those segments of the market that are covered under a community rating requirement. We strongly recommend that a community rate requirement, with narrow bands for demographic adjustments, should be applied to groups up to size 100. Until universal coverage is achieved, there should be a separate rate pool for the individual market that is subject to the same rules. Many health care reform bills call for formation of health purchasing cooperatives or alliances to pool purchasing power. It is not the alliance that pools purchasing power, it is the requirement that all health plans must use community rating to develop their premiums.

As the use of experience rating is phased out, some groups will receive premium rate increases and others will receive decreases. Health plans need a reasonable amount of time to "spread" the changes in premiums so that groups and individuals can absorb the shock of premium rate increases.

3. Because health plans will be competing directly on the basis of their ability to manage costs, and not on the basis of benefit design or risk selection, they will need to develop and implement new strategies to manage costs. These strategies will include products that rely on tighter networks of providers, new risk-sharing arrangements with providers, and new techniques to manage utilization. To implement these changes, health plans will need to renegotiate contracts with providers and educate current subscribers.

4. A health plan will have to anticipate how consumer behavior will change as a result of changes in both the products it offers and the number and types of products offered by competitors. It will be particularly difficult to predict consumer behavior if reform expands the ability of individuals to select their own health plan. Moreover, health plans will have to anticipate how consumers will behave in a market with strict new rules that change options that are available (e.g., standardized benefits, guaranteed issue, community rating requirements, and requirements to

offer coverage in all market segments), and that includes both new competitors and established competitors who are bringing their own new products to the market.

5. The state will need time to develop and test a potential risk adjustment mechanism. Prior to using a risk adjuster, the state will need to gain experience and determine the impact on premiums. And health plans will need to evaluate the impact that risk adjustment will have on their premiums.

We believe the transition should be designed to avoid unnecessary uncertainty, to allow health plans and providers to concentrate on the redesign of their health care delivery and financing arrangements, to implement the new standardized benefit packages and to prevent gaming by health plans that wish to secure a competitive advantage in the market through risk selection. Health plans need the transition period for the following activities:

- Development of organized delivery systems. A significant period of time will be needed for health plans to develop organized delivery systems in order to be competitive or reorganize their existing delivery systems.
- Development of standardized benefit packages. A significant period of time will be needed to modify all existing benefit packages, educate consumers and providers, re-rate the products and redesign all marketing and explanatory materials.
- Move to community rating. Health plans should be allowed a reasonable period of time to phase-in community rating with narrow demographic bands in the small group and individual markets. During the transition period to universal coverage, health plans should be allowed to set separate community rates for individuals and small groups.

While a transition period is necessary to implement some provisions of reform, we believe certain other provisions should have a relatively short implementation period:

- Guaranteed issue. Within a relative short time after enactment, health plans should be required to offer their small group coverage on a guaranteed issue basis, that is, without regard to health status or claims experience. Within a somewhat longer period, all health plans should be required to offer their individual coverage on a guaranteed issue basis. It is important to recognize that guaranteed issue requires the enactment of reform that will result in universal coverage. In the absence of such requirements, over time, risk selection will be more difficult to control.
- Guaranteed renewal. Immediately Upon enactment, all health plans should be prohibited from canceling coverage for reasons related to a individual's or group's health status or claims experience.
- Limits on preexisting condition waiting periods. Immediately upon enactment, all health plans should be limited in their ability to impose pre-existing condition waiting periods on new subscribers. These waiting periods should be limited to 6 months for conditions existing in the previous 6 months.
- Information. Immediately upon enactment, all health plans should be required to report information needed by the states to monitor costs, implement comprehensive reform, and develop a risk adjuster.
- Benefit package. Immediately upon enactment, all health plans should be required to maintain their current level of benefits. Health plans should have an adequate period to develop the capability to offer the standardized benefit packages.

We are excited by the prospect of federal reform that will finally put an end to competition based on risk selection and make it possible for health plans to compete fairly on the basis of their ability to manage costs and improve quality. We strongly support such reform. The time to act is now.

PREPARED STATEMENT OF WILLIAM P. LINK

Mr. Chairman and members of the Committee, thank you for the opportunity to testify today on the issue of health care reform and the role that insurance market reforms can play in achieving meaningful change to the system.

My name is William P. Link; I am Chairman and Chief Executive Officer for Group Operations of The Prudential Insurance Company of America. I am here today on behalf of the Alliance for Managed Competition ("AMC"), a coalition of five managed care companies working towards comprehensive health care reform. The AMC members, Aetna, CIGNA, Metropolitan, The Prudential, and The Travelers, collectively provide health coverage to over *60 million* Americans.

First and foremost, I want to tell you that The Prudential and the AMC believe our health care system must be changed; this was the purpose for the AMC's formation. Since its inception, the AMC has supported comprehensive health care reform legislation that would:

- Eliminate preexisting condition limitations, "cream skimming" and "cherry-picking" underwriting practices;
- Make coverage portable;
- Prohibit cancellation of coverage due to illness;
- Maintain a choice of providers;
- Reduce unnecessary paperwork and hassle in the system;
- Establish a standard benefit package;
- Expand preventive care;
- Reform the medical malpractice system;
- Establish purchasing pools for small business to increase access at reduced cost for all Americans; and
- Emphasize network-based delivery systems and use of health care quality and outcomes measures

As you know, there is no easy way to meet all the goals for reform of our health care system. But we must change the way we provide health care—away from *risk selection* to *risk management,* and we represent that change. A revolution is already underway in the marketplace among employers, individuals, providers, and our business. This is the movement towards managed care. We already see that in 1992 *51%* of all employees with employer-provided coverage are in network-based delivery systems, up from 28% in 1988—almost double in four years. Enrollment in HMOs has more than quadrupled in the last *12 years*—now totaling nearly *45 million* individuals. Overall, enrollment in managed care has increased to 90 million—eight times the level of just 10 years ago. This shift in the market is starting to have an impact on health care inflation. The Bureau of Labor Statistics data shows the rate of health care inflation steadily declining from nearly 10% in 1990 to just over 5% in 1993. From our personal experience, the results are more dramatic in some areas of the country, where plans are actually seeing real decreases in their premiums.

Health care reform can, and should, expedite these positive changes that are occurring every day across this country. The migration to managed care is having a demonstrable and positive impact on health care costs and health care quality, and our surveys show consumers like what they get. Market forces are driving health plans to compete on the basis of providing high quality, cost effective care that meets high consumer satisfaction standards. A number of the reform proposals before the Congress recognize this, and we encourage and support reform that will enhance the benefits of market competition.

Concerning the subject of today's hearing, an integral part of any legislation must be insurance market reforms. All of the major health system reform proposals include changes that were first introduced by Senators Lloyd Bentsen, then Chairman of this committee, and Dave Durenberger in 1991 to address major insurance market distortions. This legislation was passed twice by the Senate in 1992.

The essential goal of insurance market reform must be to link the delivery and financing of health care and to establish a market where health plans:

- compete on the basis of managing care, not avoiding bad risks;
- compete on the basis of efficiency and cost-effectiveness; and
- compete on the basis of spreading risk, containing cost, and improving quality.

The major distortions in today's market occur with small groups and individuals. The large group market, by contrast, has made significant progress, succeeding both to control costs and to maintain high quality care. The focus of market reforms should be the small group market, with the goal of providing that segment of the market with the same tools available today to large groups. An integral part of the effort must include creating a more efficient means of organizing, marketing, and distributing insurance for small groups through health plan cooperatives.

"Health security" for *all* individuals in small or large groups can be achieved through insurance market reforms that make health coverage portable and secure. The AMC supports key market reforms that include:

- *Community Rating.* All health plans must spread the cost of care across their entire population. Good public policy should permit adjustments for certain demographics.
- *Standard Benefits.* Health plans must compete on the basis of cost and quality, and not benefit selection.

- *Antidiscrimination.* No health plan should deny coverage to an individual on the basis of health status or medical history.
- *Preexisting Conditions.* Once individuals are in the system, whether they change jobs, become unemployed, or experience any other change in circumstances, they *should not* have to satisfy a preexisting condition exclusion. The use of a limited preexisting condition exclusion can serve as a powerful incentive for individuals to become members of a health plan rather than wait until they become ill. We need to be conscious of individuals who choose not to enter the system until they need medical care and "free ride" on the system, raising costs for others who have acted more responsibly.
- *Guaranteed Renewability.* A health plan must not be permitted to terminate coverage at renewal for any reason except for nonpayment of premiums, misrepresentation, or fraud, or if the health plan leaves the market.
- *Guaranteed Availability.* A health plan must accept all eligible individuals who wish to enroll in the plan subject, however, to reasonable limits due to financial or provider capacity.

As I outlined initially, there are a host of other changes we support. Changing the insurance market incentives however, must focus not only on the supply-side—the provider and delivery system—but also on the demand-side of the market. We support changes in the tax treatment of employer-provided health benefits for employees that will make consumers more conscious of the cost and relative value of health care, and will make consumers price sensitive to health plan premiums.

I want to comment briefly on one other issue relating to insurance reforms. The changes we have recommended will only work if health plans are financially healthy. The solvency and capital standards developed by the States are a necessary means to assure financial stability and to protect consumers.

Finally, we have concerns that some of the proposals currently under consideration will impede true reform that is already occurring in the market place.

Our first concern is with premium and budget caps. We understand that the goal of both is to ensure that costs are reduced. But these provisions are fundamentally inconsistent with achieving long term, real savings in our medical system. Virtually all health economists agree that one key to real savings is to reduce unnecessary medical treatments and provide only the services that are proven to work, as documented by outcomes data. Another key is to educate and encourage individuals to be informed purchasers of care. Premiums caps will not do this.

Managed care, however, does. But managed care has not achieved universal market penetration, and any artificial price restrictions will significantly impede its development and destroy the gains that have been realized. Significant investment is required to build the managed care infrastructure needed for effective health care reform. We estimate that $93 billion will be needed across the U.S. by managed care companies to build new primary care facilities, to expand provider networks, to provide new medical and information technology, to continuously improve quality management and member services, and to maintain required reserves and working capital.

The capital required to build this infrastructure will not be available if premium caps are imposed. Today's investors will not continue to put capital in an industry that carries the risk of artificial and politically set price restraints. There was dramatic evidence of this in 1993. Nine managed care companies lost over $7 billion in market capitalization over a two-week period (February 4, 1993 to February 22, 1993)—just in response to reports that price controls were to be imposed.

Managed care already is beginning to control costs, and is becoming even more effective in this role. As we stated at the outset, legislation should enhance this capability, not cut it off.

Our second concern is with unnecessarily large and overly regulatory Regional Health Alliances. We support pooling individuals and small employers to take advantage of economies of scale in administering plans. However, some proposals call for alliances so big (employers with 5,000 employees), and with so much regulatory power, that the alliances would undermine the very competition that is so essential to health care reform.

If every employer up to 5,000 employees is forced to join an alliance, health care for the vast majority of the American population would be controlled by such alliances. We are talking about 98% of employers and 70% of employees. Small employer alliances could enhance market efficiency, but large employer alliances would dominate markets, stifling competition and innovation. We would no longer have the benefit of the current efforts of large employers to improve health care quality and cost-effectiveness since employers' costs would no longer be tied to their own experience, but to that of the entire alliance. Also, employees of medium and large employ-

ers would be forced to change the health coverage they enjoy today, negating successful past efforts to improve quality and cost-effectiveness.

Some recommended alliance structures go way beyond addressing real problems in the system. They seek to "fix" what is not broken—coverage in the medium to large size employer market—and this is precisely what the President has said we should not do. Employees in this market are well served by these plans. Instead, we need to focus on what is broken and remedy it. Let's design health alliances for the small employer. And let's focus on how to encourage and support continuing employer innovation in employee satisfaction, cost and quality management.

Third, we are concerned with proposals that would politicize and bureaucratize the health care system. Health reform represents a complex restructuring of one-seventh of the U.S. economy. Some proposals will cost jobs; result in rationing without agreed upon standards; and disrupt the health care of many Americans.

In conclusion, I want to thank you for this opportunity to present this testimony. We support comprehensive and meaningful reform. We believe that insurance market reforms are a key element in accomplishing this goal. They will help to move the market away from one based on risk selection to a market where we compete on our ability to manage risk. Health care reform is essential and The Prudential and the Alliance for Managed Competition are committed to its achievement. We look forward to the day when all Americans will have access to the protection they need from unforeseen health costs, and all Americans can make an informed choice about their coverage based on quality, access and cost.

[Submitted by Senator Moynihan]

MUTUAL OF OMAHA,
Omaha, NE, February 17, 1994.

Hon. DANIEL MOYNIHAN,
U.S. Senate,
Washington, DC.

Dear Senator Moynihan: I understand that during testimony recently before the Finance Committee, Salvatore Curiale, Superintendent of the New York Insurance Department, reported there has not been a mass exodus of insurers or policy holders from the insurance marketplace as a result of New York State's recently enacted health insurance reform. Mutual of Omaha would like to correct the record.

In April of 1993, the state of New York instituted legislation requiring both individual and small group insurers to (a) provide health insurance coverage to anyone who wanted it, regardless of health status, and (b) charge all persons the exact same premium for this coverage. According to the *National Underwriter* (February 22 and April 12, 1993 editions), ten of twenty-four small group insurance carriers left the New York market because of the law. The withdrawal displaced 49,576 small business policyholders (*Best's Insurance Management Reports* March 15, 1993).

As a result of this new law, premiums increased for about 59% of persons insured with Mutual of Omaha individual health policies. Even the New York Department of Insurance reported that, as a result of pure community rating, rates for a single male, age 30, increased by 170 percent.

From April to November 1993, the number of Mutual of Omaha individual policies in New' York dropped by over 30%. We contacted over 450 persons who dropped their Mutual of Omaha policies. They told us they couldn't afford it anymore, so most of those people went uninsured. Unfortunately, over half of the persons who dropped their coverage were under age 35, which does not bode well for the rest of the people left in the insurance pool. If only the older and sick persons stay, premium costs will increase.

We are not suggesting that we forget about health care reform, only that insurance reforms must occur in the same direction and degree as universal coverage. Mutual of Omaha supports comprehensive health care reform including insurance market reforms, voluntary alliances and guaranteed access accomplished through universal coverage. However, we believe our real life New York experience shows, without a question, what happens to consumers when insurance reforms are implemented in a community rating setting without either an individual or employer mandate. We would strongly caution against adopting such an approach at the fed-

eral level without considering the impact on your constituents. Please call me or Bill Mattox at (202)393-6200 if we can be of assistance to you.

Sincerely,

JOHN W. WEEKLY

NEW YORK LIFE INSURANCE COMPANY,
Washington, DC, March 2, 1994.

Hon. DANIEL PATRICK MOYNIHAN,
U.S. Senate,
Washington, DC.

Att: Ms. Donna Ridenour

Dear Senator Moynihan: When New York Superintendent of Insurance Salvatore Curiale testified before the Senate Finance Committee on February 2, he used a hypothetical example involving New York Life which we would like to clarify for the record. We request that this letter be inserted in the official record of the hearing.

In illustrating a point about the need for a risk adjustment mechanism in a guaranteed issue environment, Mr. Curiale used a hypothetical example involving the Gay Men's Health Crisis Center and New York Life. We believe the Superintendent's comments were illustrative and were not meant to indicate that New York Life engaged in any improper activity and we are not aware of any basis in fact for his reference to New York Life in that context.

New York Life and its Foundation have had an active and ongoing commitment to supporting programs in the AIDS-related area in which organizations such as the Gay Men's Health Crisis Center are also involved. In addition, our Chairman, Harry Hohn, currently chairs both INSURE, an industry-funded foundation that makes grants to community-based organizations engaged in AIDS prevention and education programs for adolescents, and NCAP (the National Community AIDS Partnership), now the largest national funding organization providing resources to local communities for HIV and AIDS care and prevention.

Because of our commitment to programs such as these and our presence in the New York City community, we want to avoid any misperception that might arise from the hypothetical example used in the Superintendent's testimony. We would appreciate your help in clarifying the formal record to note that the Superintendent did not mean to imply that New York Life had done anything improper. We believe that insertion of this letter in the record would address our concerns.

Sincerely,

JESSIE COLGATE

STEPHEN I. JURMU,
Mason, MI, February 17, 1994.

Senator DANIEL P. MOYNIHAN,
Committee on Finance,
U.S. Senate,
Washington, DC.

Dear Senator Moynihan: I do not believe that the United States is in the midst of a health care crisis. I believe that the United States has the finest health care delivery system in the world. I believe that it may be appropriate for the nation to make health care more affordable to certain groups through financial assistance. I believe that the President's proposal for a socialized system of medicine is a bureaucratic nightmare which will not achieve any good purpose. I hope that you will use your influence to preserve the private health care system and to rely on the free-market to bring costs down rather then socializing the system as the President's proposal would do.

Yours very truly,

STEPHEN I. JURMU

PREPARED STATEMENT OF SENATOR DAVID PRYOR

Mr. Chairman, thank you for holding today's hearing on the important issue of insurance market reform. In the last Congress, this Committee spent a good deal of time considering this issue. Unfortunately, the insurance market problems we

heard about then remain with us today. Day after day, we continue to hear about people who cannot buy insurance because of a preexisting illness, or about small businesses for whom health coverage is unaffordable.

Although the discriminatory insurance industry practices have not changed since the Committee last visited these issues, one important change has occurred. Finally, we have a President who is exercising his leadership to fix our flawed health care system and to guarantee health security to all Americans. Insurance market reform is one of many changes we need to reach the goal of affordable health care for all.

Responding to high health care costs and attempting to limit their liability, insurance companies have turned more and more to underwriting and marketing practices that discriminate against small businesses and individuals. As a result, many seeking coverage are priced out of the market or sometimes excluded at any price.

In discussing insurance market reform, we frequently hear about problems faced by individuals and small businesses. A recent situation faced by the 7,300 people who purchase their health insurance through the Farm Bureau in my home state of Arkansas illustrates that members of large groups fall victim to discriminatory practices as well. Risk selection in large groups continues to price health insurance out of people's reach.

Late last year, members of the Arkansas Farm Bureau group received this information from their insurance company:

> It became obvious this year that the collective experience of the participants in the Farm Bureau group would require a substantial rate increase in order to maintain the actuarial integrity of the program. However, such a rate increase would have the effect of causing younger, healthier participants to switch to coverage which they could obtain elsewhere at more favorable premium rates. The older, less healthy group left would naturally cause the experience of the group to deteriorate, leading to further losses of membership and further rate increases. In short, the program could not long survive in that fashion.

The resulting policy changes meant health insurance premiums of over $24,000 per year for Robert and Mary Ann Fratesi of Pine Bluff. Premiums for Doris Bouska of Mountain Home increased from $2000 per year to over $13,000 per year. Mrs. Bouska wrote, "at this cost, you can count me as one more person with no health insurance after 30 years in Blue Cross."

The insurer in this case argues that this example clearly defines the need for universal health reform where everyone is rated together, and asserts that their policy decisions were forced by a marketplace where insurance companies manage risk by offering insurance only to healthy people.

Although insurance market reforms are a integral part of the solution to our health care crisis, market reforms alone will not give the American people health security, nor will they rein in health care costs. Mr. Chairman, I look forward to working with you and our colleagues on the Committee to pass comprehensive health care reform legislation this year. I am pleased to have the opportunity today to hear from our distinguished panel of witnesses.

COMMUNICATIONS

STATEMENT OF THE NATIONAL FEDERATION OF INDEPENDENT BUSINESSES

Thank you for the opportunity to submit testimony to the Committee on Finance on the important subject of health care reform. Over the course of a decade, NFIB has accumulated much information on the health insurance needs of the small business community and what they would like to see in a reform package. We appreciate the opportunity to share the views of our members.

BACKGROUND

Health insurance was first cited as the number one problem for small business owners in a 1986 NFIB Foundation survey, *Problems and Priorities.* Ever since that time, the cost of health insurance has been rated the number one small business problem. In recent years, it has become twice as critical as the number two problem, "federal taxes on business income." For this reason, reform of the nation's health care system has become NFIB's top priority issue.

NFIB Foundation surveys have found that small business owners view health insurance as the most important fringe benefit they make available to their employees, both out of a sense of familial obligation and competitive necessity. According to NFIB studies, firms that provide insurance tend to be the more stable, more mature, more profitable firms, and have more full time employees than their counterparts that do not offer insurance. NFIB's member businesses tend to be more stable and mature than the general small business community. As you would expect, therefore, a larger percentage of them (63%) provide health insurance as a fringe benefit than does the general small business community. Of the firms that do not offer health insurance, *most say they would if they could afford it.*

SMALL BUSINESS AND HEALTH INSURANCE COVERAGE

The question of how many employers are currently providing health insurance should be important to all those who are committed to reforming the health care system. We believe that understanding how many employers are and are not providing health benefits for their employees is a vital component in the health care debate. While the White House has indicated that the "vast majority of employers currently provide health insurance for their employees," all the data we have seen paints a very different picture.

Based on data from the Health Insurance Association of America (HIAA), the Census Bureau, the Congressional Budget Office, the U.S. Small Business Administration and others, we find that between 40 and 45 percent of all employers provide health insurance. This seemingly low percentage is driven by the huge number of employers with fewer than five employees (about 3,000,000 firms), of which only 26% provide coverage.

PERCENT OF FIRMS THAT DO AND DO NOT OFFER HEALTH INSURANCE (HIAA, 1989)

[In percent]

Firm Size	Offer	Do Not Offer
fewer than 5 employees	26	74
5–9 employees	54	46
10–24 employees	72	28
25–49 employees	90	10
50–99 employees	97	3
100 or more employees	99	1

PERCENT OF FIRMS THAT DO AND DO NOT OFFER HEALTH INSURANCE (HIAA, 1989)—Continued

[In percent]

Firm Size	Offer	Do Not Offer
Total	[1] 42	58

[1] A 1992 HIAA study adjusted this figure to 40%.

Even the U.S. Small Business Administration's estimate of insurance coverage states that 53.7% of employers provide health insurance for their employees. NFIB believes this figure is inflated because of the method used to extrapolate the data to the population as a whole. But even if the SBA figure is accepted at face value, it still contradicts claims that the "vast majority" offer health insurance coverage.

The smaller the firm is, the less likely it is to provide health insurance. Not only do these firms pay *higher administrative costs*, but health insurance premiums represent *a larger percent of payroll* because these businesses tend to employ more marginal, lower wage workers. The lower the pay is of the employee, the heavier is the burden of health insurance premiums.

In general, we have found that cost is the primary determinant of the purchase of health insurance coverage by small business owners. Health insurance is often the largest non-wage payroll item in a small firm, more than the cost of workers' compensation and liability insurance combined. Recent polls by Foster and Higgins showed a 79% increase in the cost of employee coverage over a four year period to $3,968. For many small firms, this figure can be considerably higher. Small businesses find the health insurance market extremely volatile and unpredictable, experiencing sudden cancellations and 20–300% annual premium increases. They pay 30–40% more in administrative costs than their larger counterparts, and struggle to find and retain their coverage. In order to keep their coverage, many have been forced to increase employee cost-sharing.

Employers of all sizes have been trying to find ways to control and slow rapid and unpredictable premium increases. Larger firms have been able to contain costs by self-insuring and moving into managed care arrangements. Smaller firms, however, have limited access to managed care options and are usually unable to self-insure. As a result, they are faced with expensive state mandates, state premium taxes, medical underwriting and higher administrative expenses.

SMALL MARKET REFORMS

NFIB has formulated a list of guiding principles which we believe any comprehensive reform plan should follow. Below are the insurance reform related components of that list. While the list is not all-inclusive, it does represent the results of numerous surveys of small business owners over the last several years.

- **Insurance company practices should be reformed to make health insurance coverage easier and less expensive to buy.** Being able to count on obtaining insurance with fairly stable premiums would enable more small business owners to purchase coverage for themselves and their employees. Specifically, any reforms in this arena should include elimination of the preexisting condition limitation, guaranteed access to policies regardless of medical condition, guaranteed renewal, and portability.
- **Costly state benefit mandates and anti-managed care laws should be preempted.** Enactment of certain state laws have significantly limited the availability of affordable health plans and discouraged the growth of managed care systems. State mandates alone can raise the cost of insurance 30 percent. Preempting these mandates and repealing many restrictive state anti-managed care laws would allow small business owners easier access to affordable plans and greater access to cost-saving managed care arrangements.
- **A uniform, affordable standard benefits package should be developed in consultation with business, consumers, and state and local governments.** However, regardless of who determines what is in a "basic standard benefits package," care must be taken to ensure that the plan is at a level necessary to assure adequate coverage and care, but remains affordable. As such, we should consider the packages developed by the most efficient and cost-effective health maintenance organizations. Developing "Fortune 500" type packages that are too generous will price them out of the reach of individuals and small business owners.
- **Implementing administrative and paperwork reforms.** As much as one quarter of every health care dollar in the U.S. goes to paperwork and adminis-

trative costs. Diseconomies of scale for small firms mean that more of their health care dollar—usually more than twice as much as large businesses—goes to cover paperwork and administrative costs. As such, simplifying paperwork requirements and reducing administrative costs must be a part of any health care reform. Uniform claims forms should be developed, and electronic claims filing, billing and enrollment should be more widely utilized.

- **Consumer information and education is essential.** NFIB strongly believes that informed consumers make more cost-conscious decisions relating to their health care. Currently, part of the reason that health care costs have been going up so rapidly is due to the fact that consumers have lost control of their buying power in the health care market because they are unable to comparison shop.
- **Consumer responsibility is necessary.** Most Americans are shielded from the true cost of their insurance coverage and the cost of medical care largely because the premiums are borne by employers. As a result, there is little or no incentive to search out the highest quality health product at the lowest cost, a theory fundamental in the purchasing of most other goods.
- **Health insurance purchasing groups should be formed.** By joining together to purchase health insurance, small businesses and individuals can reduce costs through administrative savings and risk-sharing While we have no proposal for a single form of purchasing group, we have concerns about the creation of *mandatory* health alliances. Developing multiple and competing voluntary purchasing groups, several in each state, best serves the health care needs of small businesses and is more likely to instill market competition to keep prices low.
- **Self-employed business owners should be allowed a permanent 100% tax deduction for health insurance Premiums.** Self-employed business owners such as sole proprietors, partnerships, and S-corporations are allowed only a 25% deduction; that deduction is temporary. Expanding and making permanent the tax deductibility of premiums would enable many of the nearly five million uninsured self-employed to buy coverage for themselves and the millions they employ.

CONCLUSION

While no health reform plan currently proposed is a perfect one, NFIB strongly believes that we need to enact a reform package that achieves three main objectives:

1. Brings down the cost of health insurance.
2. Stabilizes the often unpredictable/fluctuating health insurance system for small firms and individuals.
3. Expands insurance coverage to more Americans without an employer mandate.

Small market insurance reforms would make significant headway in reaching these objectives. Congress should seek to ensure that insurance is affordable and accessible to businesses and individuals. Simply implementing reforms that will help bring predictability and competition to the market will significantly drive down the cost of providing health insurance and will establish coverage for many of the uninsured.

We look forward to working with the committee to craft a reform measure that will control costs and encourage more small firms to purchase coverage for their employees. We hope to work with you to pass a reform measure as soon as possible in the 103rd Congress.

Thank you.

81-835 (144)

ISBN 0-16-046253-3